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ABSTRACT

This booklet is designed to help Virginia special educators, law enforcement, and child protective service professionals recognize and understand abuse and neglect of children with disabilities; improve the reporting accuracy when there is suspicion of child abuse/neglect; and provide strategies for interdisciplinary collaboration that will facilitate a sensitive and effective response. Information is provided on: (1) the relationship between child maltreatment and disabilities; (2) risk factors; (3) indicators of abuse/neglect in children with disabilities; (4) disability types; (5) interview techniques; (6) Virginia child abuse and neglect laws; (7) definitions of child abuse/neglect; (8) issues and concerns about reporting; (9) procedures for making a report; (10) a brief explanation of what happens when a report is made; and (11) abuse/neglect prevention strategies for children with disabilities. An appendix includes a glossary of disabilities, information on the continuum of disabilities and developmental language skills, a prevention curricula for children with disabilities, and a list of local social services departments. Contains 17 references. (CR)

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Assistance for
Special Educators, Law Enforcement,
and Child Protective Services in
Recognizing and Managing

ABUSE AND NEGLECT OF CHILDREN WITH DISABILITIES

ED 429 384

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COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
CHILD PROTECTIVE SERVICES

The Mandated Reporter Assistance Series

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ACKNOWLEDGMENTS

The Department of Social Services would like to acknowledge and thank our colleagues in the special education, disabilities, and law enforcement communities for devoting their time, effort, and expertise in developing this booklet.

The children portrayed in this booklet are for illustrative purposes only and are not actual victims of child abuse or neglect. The illustrations are intended to promote child safety while recognizing that children with disabilities are first and foremost children.

This booklet was written and compiled by
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TO REPORT CHILD ABUSE OR NEGLECT CALL YOUR LOCAL DEPARTMENT OF SOCIAL SERVICES DURING BUSINESS HOURS*

OR

CHILD ABUSE AND NEGLECT HOTLINE

(24 Hours a Day)

 # 1-800-552-7096

Voice/TDD Accessible

*Phone numbers for Local Departments of Social Services can be found on page 106 of this booklet.

VALUES AND PRINCIPLES

The information in this booklet is based upon the following principles:

- Children with disabilities are first and foremost children; and
- **All** children have the right to be:
  - treated fairly and with dignity;
  - protected from victimization by others; and
  - protected from re-victimization by systems designed to protect them (Crocker, 1994*).

Protection is maximized when professionals recognize childrens' abilities as opposed to focusing on their limitations.

* Adapted from: The McCreary Center Society (1993). *Sexual abuse and young people with disabilities project: investigation guidelines*, Linda Graham.

Introduction

AN OPEN LETTER TO SPECIAL EDUCATORS, LAW ENFORCEMENT, AND CHILD PROTECTIVE SERVICES PROFESSIONALS

Recognizing and investigating suspected abuse or neglect of children with disabilities is a challenging task for special educators, law enforcement, and child protective services due to many factors including: the subject matter; diversity of disabilities; characteristics of the disability, which can sometimes mask or mimic abuse or neglect; and social attitudes about people with disabilities.

Under Virginia law, you are required to report suspicion of abuse or neglect to child protective services. Collaboration that capitalizes on the expertise of each of the three professions is essential to: an objective and sensitive assessment of the situation; protection from re-victimization by systems; and ensuring the safety of the child.

This booklet is designed to help you recognize and understand abuse and neglect of children with disabilities; improve the reporting accuracy when there is suspicion of child abuse/neglect; and provide strategies for interdisciplinary collaboration that will facilitate a sensitive and effective response.

This booklet contains information on:

- The relationship between child maltreatment and disabilities;
- Risk factors;
- Indicators of abuse/neglect in children with disabilities;
- Disability types;
- Interview techniques;
- Virginia child abuse and neglect laws;
- Definitions of child abuse/neglect;
- Issues and concerns about reporting;
- Procedures for making a report;
- A brief explanation of what happens when a report is made; and
- Abuse/neglect prevention strategies for children with disabilities.

Your expertise and collaboration is essential to ensuring the safety of Virginia's children.

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1

Child Abuse/Neglect and Disabilities

1

THE RELATIONSHIP BETWEEN DISABILITIES AND MALTREATMENT

A review of the literature provides the following information on the relationship between disabilities and maltreatment:

- **Child maltreatment can cause disabilities.** The National Coalition on Abuse and Disabilities estimates that 18,000 children per year are permanently disabled by abuse and neglect or suffer mental retardation or sensory and motor impairments.

- **Disability increases the risk of maltreatment.** A 1993 national study sponsored by the National Center on Child Abuse and Neglect indicates that children with disabilities are abused at a rate of 1.7 times that of children without disabilities.

  Children with disabilities are 1.6 times more likely to be neglected, 1.8 times more likely to be physically abused, and 2.2 times more likely to be sexually abused than children without disabilities (Sullivan, Knutson, Scanlan, & Cork, 1997).

- Circumstantial factors such as **chronic substance abuse or violence in families can substantially increase the risk for abuse and disability** (Sobsey, 1994).

- While families often effectively manage the special needs of children with disabilities, **the risk for maltreatment by other care givers remains.**

- **All research studies indicate that underreporting is a major concern.**

BELIEFS AND MISCONCEPTIONS ABOUT CHILDREN WITH DISABILITIES

Some researchers suggest that children with disabilities have increased vulnerability to abuse because of society's response to the disability, rather than the disability itself. These social attitudes and misconceptions include (Sobsey, 1994):

- Belief that children with disabilities are sheltered from harm and denial that abuse or neglect is perpetrated.
- A belief that children with disabilities are less valuable than other children.
- A belief that children with disabilities are less credible than other children.

continued

1

BELIEFS AND MISCONCEPTIONS ABOUT CHILDREN WITH DISABILITIES

continued

- Devaluation of the impact of abuse and neglect when the victim is a person with a disability.
- Belief that people with disabilities are infantile or asexual and lack the sensitivity or intelligence to suffer from the abuse they endure.
- Belief that the victim has provoked their own abuse, i.e. "blaming the victim."
- Professional reluctance to accept evidence that colleagues are abusing the children they serve.
- Use of "aversive procedures" by service providers masquerading as intervention or treatment.

Belief in these myths has contributed to society's failure to recognize the potential for abuse, detect incidents when they occur, and provide victims with needed protection.

Examining these misconceptions and improving social attitudes about children with disabilities is a critical first step toward ensuring their safety and ultimately preventing child abuse and neglect (Sobsey, 1994).

AT RISK CHILDREN WITH DISABILITIES

Many risk factors for abuse and neglect of children with disabilities are the same as those for children without disabilities.* Some risk factors, however, are related to the presence of a disability (Perinatal Progress, 1997).

- Life long dependency can render a child more trusting and less likely to question caregiver actions.
- Due to dependency on caregivers and "learned compliance," children with disabilities may be less likely to complain if someone hurts them.
- Many children with disabilities have restricted circles of friends or acquaintances and may not report due to fears of jeopardizing their relationship with, or losing, the abuser. They may fear retaliation.
- Some children with disabilities lack information about body boundaries/ownership, abuse, and self-protection.
- Some children with disabilities may have less understanding of what constitutes "right" or "wrong" behavior.
- Some children with disabilities may be more likely to "go along with" activities that are not appropriate.
- Some children with disabilities exhibit self-injurious behavior, leading to difficulty in discerning the source of the abuse.
- Many children with physical disabilities are less able to defend themselves, avoid, or escape the abuse.
- Many children with disabilities cannot communicate clearly and thus cannot report what has happened to them.
- Sometimes children with disabilities who can communicate are not believed **

SEXUAL ABUSE

- Some children with disabilities lack knowledge about sexuality and abuse and, therefore, may not discern that sexual contact is abusive.
- Dependency on caregivers for close personal care such as dressing, bathing, and toileting may lead to increased opportunity for intrusive touching.

* Refer to the section in this booklet on Family Stress and Risk.

**Increased vulnerability associated with the presence of a disability should never be used to rationalize abusive acts or blame the victim for "allowing" him/herself to be victimized.

1

PERPETRATORS

Children with disabilities are often maltreated by persons they know and trust including parents, family members, and other caregivers. Since children with disabilities are routinely in contact with and dependent upon service providers, the risk of maltreatment, especially sexual abuse by service providers, is increased.

Perpetrators who maltreat children with disabilities often share the following characteristics* (Sobsey, 1994):

- **Perpetrators of sexual abuse are predominantly male.**
- **Perpetrators typically have a strong need for power and control.** Often, they are in a position of authority over their victims whom they perceive as powerless, vulnerable, and/or unable to accuse them. Their interactions with victims are marked by power inequities and domination.
- **Perpetrators often were victims of abuse as children or were exposed to other abusive environments.**
- **They may justify their behavior by claiming the victim "provoked" it.** Perpetrators emphasize the victim's differences rather than similarities to persons without disabilities, lack empathy, and minimize personal responsibility.
- **Many perpetrators lack control over impulsive behavior which is sometimes associated with substance abuse or brain damage.**

* Not all perpetrators have these characteristics and some persons who exhibit these characteristics are not perpetrators.

CONSEQUENCES OF ABUSE AND NEGLECT

Research indicates that the consequences of maltreatment for children with disabilities are similar to those for their able-bodied peers and can affect the child's physical, emotional, social, and cognitive development. Consequences of maltreatment include:

- mild to severe physical injuries;
- death;
- sexually transmitted diseases;
- pregnancy;
- emotional distress including anger, anxiety and fearfulness, depression, and low self-esteem;
- social withdrawal;
- impaired ability to trust;
- learning difficulties;
- post traumatic stress disorder;
- maltreatment related disabilities; and
- tendencies toward re-victimization.

In addition, people who witness or experience abuse may be more likely to perpetrate abuse upon others.

2

Disabilities and the Family

2

FAMILY STRESS AND RISK

While many parents of children with disabilities experience stress related to their child's disability, behavior, or need for services, most parents do not respond abusively. Results of contemporary research has lead to decreased emphasis on the importance of family stress as a causal factor in the abuse of children with disabilities (Sobsey, 1994).

The factors that need to be considered for determining risk for abuse within families where there is a member with a disability are the same factors that are associated with risk in other families. These risk factors are without regard to socioeconomic status, race, culture, or ethnicity and include:

- family isolation;
- disruptions in parent-child attachment;
- unrealistic expectations of the child;
- family member attributes such as
  - poor impulse control,
  - low self-esteem, and
  - a need to exert control over others;
- substance abuse; and
- a family history of violence.

Families who perceive themselves as severely stressed and as having difficulties coping should be offered assistance. They are often aware of the source of stress and know what kind of help is needed. Intervention should be tailored to the unique needs of the family and can include access to needed resources; development of support networks; and/or support of marital and family relationships (Sobsey, 1994).

EMOTIONAL RESPONSE TO THE DISABILITY

The birth of a child with a disability or discovery that a child has a disability has a profound effect upon the family and alters its configuration. Parents of newborns diagnosed with a disability experience shock, loss, disappointment, and grief. They go through stages of mourning similar to families mourning the death of a loved one. These stages are characterized by (Crocker, 1994):

- denial;
- anger;
- depression;
- adaptation; and
- acceptance.

Unlike the sequential stages of mourning associated with death, however, mourning in families of children with disabilities is cyclical and often triggered by developmental milestones such as walking, talking, entry into school, adolescence, and adulthood or the age that most children leave home. Parents may feel they've accepted the disability only to discover a new challenge. New challenges and associated sorrow can last a lifetime (Crocker, 1994).

2

IMPACT OF A CHILD'S DISABILITY ON FAMILY LIFE

YOUNG CHILDREN

Parents and other caregivers may experience added stress in caring for young children with disabilities because (Perinatal Progress, 1997):

- As infants, they may cry more or be harder to soothe than other babies. Some babies need almost constant care.
- Infants with disabilities may not smile, make eye contact, or enjoy cuddling. It may be harder for parents to become attached and to feel protective of their children.
- Long hospital stays, especially soon after birth, interfere with important bonding time needed by parents to develop loving and protective feelings toward their new child.
- Young children with disabilities may not reach developmental milestones as early as other children including walking, talking, toilet training, or getting dressed without help. If the child doesn't reach developmental milestones when expected, the parent may feel frustrated, helpless, angry, or a sense of failure.
- Young children with disabilities may have behaviors that are difficult to handle, leading to heightened frustration by caregivers.

FAMILY CONFIGURATION

When a child is diagnosed with a disability, the family configuration is altered. Changes may be seen in family relationships, employment, housing, medical care needs, or child care demands as described below (Perinatal Progress, 1997; Sullivan, Knutson, Scanlan, & Cork, 1997):

- A child with a disability may need more daily care than other children such as lifting and assistance with dressing, bathing, and toileting. There may be extra laundry or cleaning.
- Adaptations to the home and furnishings may be needed.
- There may be increased financial demands associated with medical or educational needs and equipment or adaptive devices.
- There can be difficulty obtaining affordable, trained child care resulting in limited leisure time or restricted social activities for the caregivers.
- The child may have chronic or multiple medical needs requiring a great deal of time and care.
- Physical and emotional fatigue may rob parents of the energy needed for other activities and relationships with their spouse, children, and extended family members.

- For some disabilities, family members may be faced with new communication demands and may need to attain some level of fluency in the use of sign language, communication boards, or augmentive communication devices.

- Families may feel isolated and need support and understanding from families facing similar challenges.

- Parents have to assume strong advocacy and case management roles concerning needed services for their child.

- Siblings have to adjust to a brother or sister who, because of the disability, may require large amounts of family time, attention, money, and/or psychological support.

- Siblings may feel resentment or anger toward their brother or sister. Suppressed feelings of frustration, anger, and guilt can lead to sadness and sometimes depression. (Capper, 1996).

- Due to limited life experiences and identification with their brother or sister, siblings need information to allay their fears and put the disability into perspective.

- **The child with a disability may experience:**

  - frustration at not being able to make him/herself understood;

  - unhappiness at being left to play alone;

  - withdrawal due to a lack of social skills;

  - irritation over constant reminders about everything;

  - low self-esteem; and

  - anger resulting from an inability to do things as easily and quickly as their siblings (NICHY, News Digest, 1988).

2

FAMILY RESILIENCY AND HEALTHY ADJUSTMENT

While parenting a child with a disability has its challenges, it also has its rewards that include:

- close family bonds from working together as a team;
- learned patience and compassion for others; and
- family pride associated with achievements.

Families of children with disabilities, like other families, are best able to provide a safe, nurturing environment for their children when they have community and family supports and strong attachments among all family members. Specifically, families who have made a healthy adjustment to their child's disability exhibit the following characteristics (Sullivan, Knutson, Scanlan, Cork, 1997):

- They view their child as a child first; the disability is secondary.
- They are not preoccupied with why the condition happened.
- They focus on positive attributes of their child rather than negative aspects of the disability.
- They seek and use information about the disability to facilitate their understanding and work with their child.
- They are cognizant of the educational implications of the disability and are familiar with available programs and communication methods or assistive devices needed by their child.
- They are aware of available support groups for parents and children with disabilities.
- They manage the needs and demands of the child with a disability within the context of family life.
- The father has an active role in parenting his child with a disability which serves to provide support for the mother and a gender balance that is beneficial to the child's social development.
- There is good communication within the family.
- The family has support from friends and/or relatives.
- Caregivers have opportunities for respite and time available to take care of themselves.

OBSTACLES TO ACCESSING COMMUNITY RESOURCES

Specialized professional and community resources are essential for families of children with disabilities. Unfortunately, families often encounter obstacles to accessing needed services including:

- nonexistent resources;
- denial of services due to not meeting eligibility criteria;
- impersonal or inappropriate services, including culturally non-responsive services;
- lack of professional expertise;
- lack of transportation or money for services;
- lack of time;
- needs of other family members;
- resistance to services from the child with a disability;
- lack of knowledge of resources or need for services; or
- physical, cognitive, or emotional disability of the parent(s) (Virginia Institute for Social Services Training Activities, 1996).

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PARENTS WITH DISABILITIES

Many parents with disabilities are able to provide adequate care and nurturance of their children, especially when they have support from their families and/or community services.

Assessment of the impact of the disability on the parents' ability to nurture, supervise, and meet the developmental needs of their children must be done on a case by case basis. The following factors should be considered:

- the nature and severity of the parent's disability;
- impact of the disability on parental judgment and behavior;
- **demonstrable adverse effects on the safety and care of the child; and**
- the availability and use of formal and informal support sytems.

A threat to the child's safety should not be assumed merely because the parent has a disability.

As in those situations of suspected child maltreatment where the parents are not disabled, the parents should be offered assistance in meeting their responsibilities toward their children and, if needed, a protective plan developed.

MENTAL RETARDATION

Assessment of the impact of mental retardation on the parents' ability to meet their child's developmental and safety needs must be done on a case by case basis taking into consideration the factors previously described.

In addition, parents with mental retardation have special challenges related to parenting that may include (Stehle, 1992):

- Social biases that they cannot be competent parents.
- Social expectations that they'd never become parents.
- Low self-esteem due to past segregation and social and academic failure.
- Difficulty with intimacy and an inability to read cues.

  Many adults with mental retardation were excessively controlled as children by external rewards. As a result, they often rely on the direction of others and may have difficulty independently picking up on their child's cues.

- Limited opportunities to learn problem solving skills.

Research has shown that mothers with mental retardation who have been raised in institutional group care have more frequent and severe parenting difficulties than women raised in family care, due to the lack of exposure to parenting role models (Sobsey, 1994).

3

Recognizing Child Abuse and Neglect

3

LEGAL DEFINITIONS

Section 63.1-248.2 of the Code of Virginia defines an abused or neglected child is any child **under 18 years of age whose parents or any person responsible for his or her care*** (such as a child care provider, foster parent, teacher, or anyone responsible for the welfare of a child receiving residential care at an institution):

1. causes or threatens to cause a nonaccidental physical or mental injury;

2. neglects or refuses to provide adequate food, clothing, shelter, emotional nurturing or health care;

3. abandons the child;

4. neglects or refuses to provide adequate supervision in relation to a child's age and level of development; or

5. commits or allows to be committed any illegal sexual act upon a child, including incest, rape, indecent exposure, prostitution, or allows a child to be used in any sexually explicit visual material.

6. Infants who have been medically diagnosed for exposure to non-prescription, controlled substances during pregnancy are also considered abused or neglected. Attending physicians are required to report these cases.

* NOTE: This section of the code also requires mandated reporters to report all cases of suspected child abuse or neglect to child protective services regardless of the abuser/neglector's relationship to the child.

OPERATIONAL DEFINITIONS

Many people think that "child abuse" is limited to physical harm. In reality, child abuse includes:

- physical abuse;
- physical neglect;
- sexual abuse; and
- emotional maltreatment.

Physical injuries, severe neglect, and malnutrition are more readily detectable than the subtle, less visible injuries which result from emotional maltreatment or sexual abuse. However, all categories of abuse endanger or impair a child's physical or emotional health and development and, therefore, demand attention.

PHYSICAL ABUSE

Physical abuse is defined as any act which, regardless of intent, results in a nonaccidental physical injury. Inflicted physical injury most often represents unreasonably severe corporal punishment. This usually happens when the caretaker is frustrated or angry and strikes, shakes, or throws the child.

Intentional, deliberate assault such as burning, biting, cutting, and twisting limbs are also included in this category.

PHYSICAL NEGLECT

Physical neglect is defined as the failure to provide for a child's physical survival needs to the extent that there is harm or risk of harm to the child's health or safety. Physical neglect is often chronic in nature.

Physical neglect may include, but is not limited to:

- abandonment;
- lack of supervision;
- lack of adequate bathing and good hygiene;
- lack of adequate nutrition;
- lack of adequate shelter; and
- lack of medical or dental care.*

* Refer to the section in this booklet on Failure to Obtain Medical Care.

continued

3

OPERATIONAL DEFINITIONS

continued

SEXUAL ABUSE

Sexual abuse is defined as acts of sexual assault and sexual exploitation of minors. Sexual abuse encompasses a broad range of behavior and may consist of many acts over a long period of time or a single incident. Sexual abuse is generally perpetrated by someone known to the child and often does not involve violence. Victims include males and females who range in age from less than one year through adolescence. Specifically, sexual abuse includes:

- incest;
- rape;
- intercourse;
- oral-genital contact;
- fondling;
- sexual propositions or enticement;
- indecent exposure;
- child pornography; or
- child prostitution.

The nature of sexual abuse, the shame of the child victim, and the possible involvement of trusted parents, stepparents, or other caretakers make it extremely difficult for children to come forward to report sexual abuse.

EMOTIONAL MALTREATMENT

Just as physical injuries can scar and incapacitate a child, emotional maltreatment can similarly cripple a child emotionally, behaviorally, and intellectually.

Varying degrees of emotional and behavioral problems are common among children who have been emotionally abused. Emotional maltreatment can include **patterns** of:

- Verbal assaults (e.g., screaming, intimidating, rejecting, ridiculing, blaming, sarcasm);
- ignoring and indifference; or
- constant family conflict.

Emotional abuse can be seen as a self-fulfilling prophecy. If a child is degraded enough, the child will begin to live up to the image communicated by the abusing parent or caretaker.

Cases of emotional abuse are difficult to prove. A cause and effect relationship between the parent or caretaker's acts and the child's response must be established. These cases should be referred for evaluation and treatment as soon as possible.

INDICATORS OF PHYSICAL ABUSE

Indicators should be considered together with the explanation provided, the child's developmental and physical capabilities, and behavioral changes.

PHYSICAL INDICATORS

Questionable Bruises and Welts:

- on face, lips, mouth
- on torso, back, buttocks, thighs
- in various stages of healing
- clustered, forming regular patterns
- reflecting shape of article used to inflict (electric cord, belt buckle)
- on several different surface areas
- regularly appear after absence, weekend, or vacation
- human bite marks

Questionable Burns:

- cigar, cigarette burns, especially on soles, palms, back, or buttocks
- immersion burns (sock-like, glove-like, doughnut shaped on buttocks or genitalia)
- patterned like electric burner, iron, etc.
- rope burns on arms, legs, neck, or torso

Questionable Fractures:

- to skull, nose, facial structure
- in various stages of healing
- multiple or spiral fractures

Questionable Lacerations or Abrasions:

- to mouth, lips, gums, eyes
- to external genitalia

continued

3

INDICATORS OF PHYSICAL ABUSE

continued

CHILD BEHAVIORAL INDICATORS

- Uncomfortable with physical contact
- Wary of adult contacts
- Apprehensive when other children cry
- Behavioral extremes:
  aggressiveness, or
  withdrawal
- Frightened of parents
- Afraid to go home
- Arrives at school early or stays late as if afraid to be at home
- **Reports injury by parents**
- Complains of soreness or moves uncomfortably
- Wears clothing inappropriate to weather to cover body
- Chronic runaway (adolescents)
- Reluctance to change clothes for gym activities (attempt to hide injuries, bruises, etc.)

CARETAKER CHARACTERISTICS

- History of abuse as a child
- Uses harsh discipline inappropriate to child's age, transgression, and condition
- Offers illogical, unconvincing, contradictory, or no explanation of child's injury
- Significantly misperceives child (e.g. sees him as bad, stupid, different, etc.)
- Psychotic or psychopathic personality
- Misuses alcohol or other drugs
- Attempts to conceal child's injury or to protect identity of person responsible
- Unrealistic expectations of child, beyond child's age or ability

INDICATORS OF PHYSICAL NEGLECT

Indicators should be considered together with the explanation provided, the child's developmental and physical capabilities, and behavioral changes.

PHYSICAL INDICATORS

- Consistent hunger, poor hygiene, inappropriate dress
- Consistent lack of supervision, especially in dangerous activities or long periods
- Unattended physical problems or medical needs
- Abandonment

CHILD BEHAVIORAL INDICATORS

- Begging, stealing food
- Extended stays at school (early arrival and late departure)
- Constant fatigue, listlessness, or falling asleep in class
- Alcohol or drug abuse
- Delinquency
- **States there is no caretaker**
- Frequently absent or tardy
- Shunned by peers

CARETAKER CHARACTERISTICS

- Misuses alcohol or other drugs
- Maintains chaotic home
- Evidence of apathy or hopelessness
- Mentally ill or diminished intelligence
- History of neglect as a child
- Consistent failure to keep appointments

3

INDICATORS OF SEXUAL ABUSE

Indicators should be considered together with the explanation provided, the child's developmental and physical capabilities, and behavioral changes.

PHYSICAL INDICATORS

- Difficulty walking or sitting
- Torn, stained, or bloody underclothing
- Pain or itching in genital area
- Bruises or bleeding in external genitalia, vaginal, or anal areas
- Venereal disease, especially in pre-teens
- Pregnancy

CHILD BEHAVIORAL INDICATORS

- Unwilling to change for gym or participate in physical education class
- Highly sexualized play
- Bizarre or unusual sexual behavior or knowledge
- Detailed and age-inappropriate understanding of sexual behavior (especially younger children)
- Unusually seductive behaviors with peers and adults
- Poor peer relationships
- Delinquent or run away (especially adolescents)
- **Reports sexual assault by caretaker**
- Threatened by physical contact
- Suicide attempt (especially adolescents)
- Role reversal, overly concerned for siblings
- Unexplained money or "gifts"
- Deterioration in academic performance
- Excessively concerned about homosexuality (especially boys)
- Sudden noticeable changes in behavior

CARETAKER CHARACTERISTICS

- Extremely protective or jealous of child
- Encourages child to engage in prostitution or sexual acts in the presence of caretaker
- Sexually abused as a child
- Misuses alcohol or other drugs
- Non-abusing caretaker/spouse is frequently absent from the home, permitting access to child by abusing caretaker/spouse

INDICATORS OF EMOTIONAL MALTREATMENT

Indicators should be considered together with the explanation provided, the child's developmental and physical capabilities, and behavioral changes.

PHYSICAL INDICATORS

- Speech disorders
- Lags in physical development
- Non-organic failure-to-thrive
- Learning problems

CHILD BEHAVIORAL INDICATORS

- Habit disorders (sucking, biting, rocking in an older child)
- Conduct disorders (antisocial, destructive)
- Neurotic traits (sleep disorders, inhibition of play)
- Behavior extremes:
  compliant, passive, undemanding
  aggressive, demanding, rageful
- Overly adaptive behavior:
  inappropriately adult (e.g. parents other children)
  inappropriately infantile or emotionally needy
- Developmental lags (emotional or intellectual)
- Delinquent behavior (especially adolescents)
- Self-destructive, attempted suicide
- Cruel behavior, seeming to get pleasure from hurting others and/or animals

CARETAKER CHARACTERISTICS

- Blames or belittles child
- Ignores or rejects
- Withholds love
- Treats siblings unequally
- Seems unconcerned about child's problems
- Unreasonable demands or impossible expectations without regard to child's developmental capability

3

INDICATORS OBSERVED IN THE CLASSROOM

Indicators should be considered together with the explanation provided, the child's developmental and physical capabilities, and behavioral changes.

Abused and neglected children may be found in any classroom in any school in any community in the country.

Schools are the only place in which children are seen daily over periods of time by professionals trained to observe their appearance and behavior. The school setting offers a continuum of time for observation and an opportunity to compare and contrast behaviors which are normal with those which are abnormal. Educators, therefore, may be aware that something is not right with a child long before severe physical injury is present.

The following indicators of abuse and neglect can be observed in the classroom setting. This list is intended to supplement the other physical and behavioral indicators described in this booklet:

- **The child tells you about an abusive or neglectful situation;**
- There are frequent or unexplained absences;
- Bruises or injuries are evident after an absence. (Abusive parents may keep children home after a beating in an effort to conceal bruises or injuries.);
- The child arrives at school early or stays late as if afraid to go home or no caretaker;
- The child is afraid to go home;
- The child is reluctant to change clothes for gym activities in an attempt to hide injuries, bruises, etc.;
- The child wears clothing inappropriate to the weather to cover body;
- The child displays consistent hunger, and/or poor hygiene;
- The child suffers from constant fatigue, listlessness, or consistently falls asleep in class;
- There are sudden changes in the child's behavior or academic performance. (Children act as barometers of their family environment. A sudden change in behavior or an abrupt drop in a child's academic performance may indicate a change in the home life which has affected the child.); or
- The child frequently complains of pain and/or injury without apparent injury or illness.

4

Questionable Situations

4

THE FINE LINE BETWEEN ABUSE AND DISCIPLINE

In order for children to grow up and become productive members of society, subject to society's norms, values, and rules, all children need discipline. **Discipline is a learning process designed to teach appropriate behaviors.**

Unlike discipline, **abuse is not a learning process. It is designed to stop behavior through inflicting pain.** It does not teach alternative, correct behavior. Therefore, abused children do not learn correct behavior. They learn to avoid punishment.

The intent of the reporting law is not to interfere with appropriate parental discipline but to respond to extreme or inappropriate caretaker actions. **Actions that are excessive or forceful enough to leave injuries are considered abusive.**

DISTINGUISHING ABUSE FROM ACCIDENT

The very nature of childhood invites accidents. Children are curious and fearless. They run, climb, jump, and explore. A child's motor skills usually outpace cognitive skills allowing him/her to approach danger without recognizing it. The following is a guide to help you distinguish between accidental and nonaccidental injuries.

When observing an injury you suspect might be the result of abuse, consider:

- **Location of the injury.** Certain locations on the body are more likely to sustain accidental injury. They include the knees, elbows, shins, or forehead.

  Protected body parts and soft tissue areas, such as the back, thighs, genital area, buttocks, back of the legs, or face, are less likely to accidentally come into contact with objects which could cause injury.

- **Number and frequency of injuries.** The greater the number of injuries, the greater the cause for concern. Unless the child is involved in a serious accident, he/she is not likely to sustain a number of different injuries accidentally. Multiple injuries in different stages of healing may indicate abuse.

- **Size and shape of the injury.** Many nonaccidental injuries are inflicted with familiar objects: a stick, a board, a belt, a hair brush. The marks which result bear strong resemblance to the object which was used. Accidental marks resulting from bumps and falls usually have no defined shape.

- **Description of how the injury occurred.** If an injury is accidental, there should be a reasonable explanation of how it happened that is consistent with the appearance of the injury. When the description of how the injury occurred and the injury are inconsistent, there is cause for concern. For example, it is not likely that a fall from a wheelchair onto a rug would produce bruises all over the body.

- **Consistency of injury with the child's developmental capability.** As a child grows and gains new skills, his/her ability to engage in activities which can cause injury increases. A toddler trying to run is likely to suffer bruised knees and a bump on the head. He/she is less likely to suffer a broken arm than is an eight-year-old who has discovered the joy of climbing trees.

  When assessing an injury, consider whether the child is developmentally capable of causing his or her own injuries. Also consider the child's size and whether he/she is able to generate sufficient force to create injury.

Remember that accidents do happen. Parents are not perfect. Injuries do occur that might have been avoided. Nevertheless, there is cause for concern when injuries recur and/or the explanation is inconsistent with the injury or the child's developmental abilities.

4

CHARACTERISTIC OF THE DISABILITY OR ABUSE?

The Code of Virginia requires the reporting of suspected child maltreatment by teachers, law enforcement officers, and social workers. However, there are often practical problems in identifying maltreatment of children with disabilities because the symptoms of abuse may be masked by the disability or characteristics of the disability can mimic child abuse indicators. For example:

- Some children with disabilities may be limited in their ability to communicate information about an abusive incident.
- Some children with behavioral impairments or mental retardation engage in self-abusive behaviors or are prone to accidental injury.
- Some children with physical disabilities require greater assistance with personal care routines such as dressing, bathing, and toileting at a later chronological age than their able bodied peers. Personal care routines may result in occasional touching of sexual parts of the body with resultant difficulty discerning if the touch was accidental, required, or exploitive.

Suggested areas for assessment to help discern whether the presenting situation is characteristic of the disability or indicative of abuse or neglect include:

- observation of the injury;
- the child's statements;
- consistency of injury with explanation given;
- consistency of the injury with the child's developmental and/or physical capabilities;
- witnesses to the incident;
- medical findings; and
- the child's behavior.

The best rule of thumb in discerning maltreatment is to know what is normal for that particular child. When assessing the child's behavior, it is important to:

- examine the history of the behavior;
- obtain a behavioral "baseline;" and
- determine whether there has been a clear behavior change that has taken place during the time frame in question. Consider any changes in the **intensity and duration** of the behavioral episodes (Crocker, 1994).

The following behaviors, especially when corroborated with other evidence, may indicate sexual abuse:

- increased masturbation;
- touching others, especially if new behavior;
- new and odd behaviors related to child's own genitals i.e. pulling, punching, rubbing, inserting objects into orifices;
- irritability with related behaviors;
- fears; and
- sexual drawings (Virginia Department for the Visually Handicapped, 1998).

The Code of Virginia requires that you report **suspicions** of abuse or neglect.* You need not prove that abuse or neglect has taken place; local social services departments are responsible for making this determination.

* Refer to the sections in this booklet on Indicators of Abuse and Neglect for assistance in determining suspicion of child maltreatment.

4

LATCHKEY CHILDREN

Virginia statutes do not set a specific age after which a child legally can stay alone. Age alone is not a very good indicator of a child's maturity level. Some very mature 10-year-olds may be ready for self care while some 15-year-olds may not be ready due to emotional problems or behavioral difficulties.

In determining whether a child is capable of being left alone and whether a parent is providing adequate supervision in latchkey situations, child protective services (CPS) will assess several areas. These areas include:

- **Child's level of maturity.** CPS will want to assess whether the child **is physically capable** of taking care of him/herself; **is mentally capable** of recognizing and avoiding danger and making sound decisions; **is emotionally ready** to be alone; knows what to do and whom to call if an emergency arises; and **has special physical, emotional, or behavioral challenges** that make it unwise to be left alone. **It is important to note that a child who can take care of him/herself may not be ready to care for younger children.**
- **Accessibility of those responsible for the child.** CPS will want to determine the location and proximity of the parents, whether they can be reached by phone and can get home quickly if needed, and whether the child knows the parents' location and how to reach them.
- **The situation.** CPS will want to assess the time of day and length of time the child is left alone; the safety of the home or neighborhood; whether the parents have arranged for nearby adults to be available in case a problem arises; and whether there is a family history of child abuse or neglect.

SEXUAL ACTIVITY BETWEEN CHILDREN

Situations of sexual activity between children are reportable to child protective services when:

- the perpetrator is in a caretaking role;
- there is suspected lack of supervision by the parent or adult caretaker, thereby, enabling the activity to take place.

The following variables should also be considered when assessing sexual activity between children:

- whether the activity is considered to be normal sexual curiosity that is developmentally appropriate;
- the age difference between the victim and perpetrator;
- the use of force or violence;
- the nature and frequency of sexual activity; and
- the existence of a power differential, knowledge differential, and gratification differential between perpetrator and victim.

Children who perpetrate sexual assault against other children may themselves be victims. Child perpetrators should be referred for mental health evaluation.

Perpetrators who are age 12+, engage in repetitive sexually exploitive behaviors, use violence, or demonstrate other anti-social behaviors also should be referred to law enforcement for possible prosecution due to difficulties with self-control and associated risk to the community.

4

FAILURE TO OBTAIN MEDICAL CARE

Failure of the parent or caretaker to provide needed **health care treatment** for a condition which, if untreated, could result in illness, developmental delays, or endangerment is reportable to child protective services (CPS) as medical neglect.

Children at increased risk for medical neglect and for whom the consequences are serious include children with medically diagnosed diseases or disabilities and children under the care of physician sub-specialists or allied health care specialists, due to a medical diagnosis.

Failure to obtain treatment, however, must be considered in light of:

- the availability of resources;
- the parents' financial ability to provide;
- the parent's cultural and religious beliefs; and
- **the spectrum of seriousness as to the consequences of failure to obtain needed medical care.**

Parental failure to obtain needed medical care due to ignorance, misunderstanding, or poverty is not medical neglect. A report to CPS should be considered after counseling, referral, and offers of financial or other aid are refused.

Failure to provide **preventive** health care, including immunizations, does not constitute abuse or neglect under Virginia statutes.

SITUATIONS THAT ARE NOT CONSIDERED ABUSE/NEGLECT AND ARE NOT REPORTABLE

With the rapid growth in the number of reports concerning the care of children, the Department of Social Services recognizes the need to carefully define those services which child protective services (CPS) can provide. The Department of Social Services believes that the well-being of children is a shared community concern; however, some problems are not appropriate for CPS intervention. These problems can be more effectively addressed by other community agencies.

FAILURE TO USE SEAT BELT RESTRAINTS AS REQUIRED BY LAW

Virginia law requires the use of seat belts to restrain children. The intent of the law is to protect children from serious injury in the event of an accident. The seat belt statute is a civil law with designated fines and penalties. Law enforcement authorities are responsible for enforcing this statute.

EDUCATIONAL NEGLECT

The Department of Social Services recognizes that a child missing an education is a serious community problem. Schools possess statutory authority that CPS does not have to address a child's failure to attend school or approved alternative study program. Schools are encouraged to fulfill their statutory responsibilities and exhaust all remedies before involving CPS in the following situations:

- failure of the caretaker to enroll a child in school or to provide education in accordance with the Code of Virginia;
- as a result of the caretaker's action or inaction, the child fails to meet his/her legal obligation for school attendance; or
- the caretaker refuses to permit, or does not cooperate with the school, in assessing the need for remedial or other special services for a child.

(NOTE: In some situations, a child's failure to attend school may be correlated with abuse or neglect. Refer to the section in this booklet on Indicators of Abuse and Neglect.)

5

Reporting Child Abuse and Neglect

5

WHY REPORT?

The purpose of required reporting is to identify suspected abused and neglected children as soon as possible so that they can be protected from further harm.

Child protective services cannot act until a report is made. Consequently, as a professional you play a critical role in preventing any future harm to children.

Without detection, reporting, and intervention, these children may remain victims for the rest of their lives. Abused children don't just grow up and forget their childhood. They carry physical and emotional scars throughout their lives, often repeating the pattern of abuse or neglect with their own children.

WHO MUST REPORT?

Anyone may report abuse or neglect; however, under Virginia law, certain professionals are required to report. These professionals include:

- persons licensed to practice medicine or any of the healing arts;
- hospital residents or interns;

- persons employed in the nursing profession;
- **social workers;**
- probation officers;
- **teachers or other persons employed in a public or private school, kindergarten, or nursery school;**
- persons providing full or part-time child care for pay on a regular basis;
- accredited Christian Science practitioners;
- mental health professionals;
- **law enforcement officers;**
- professional staff persons employed by a public or private hospital, institution, or facility in which children are placed;
- persons associated with or employed by any private organization responsible for the care, custody, and control of children; and
- mediators certified to receive court referrals.

LIABILITY OF THE REPORTER

Section 63.1-248.5 of the Code of Virginia provides protection from criminal and civil liability to the following persons unless it is proven that these persons acted with malicious intent:

- any person making a report of child abuse/neglect and
- any person who participates in a judicial proceeding resulting from either making a report or taking a child into immediate custody.

PENALTY FOR FAILURE TO REPORT

Section 63.1-248.3 of the Code of Virginia provides penalties for failure to report suspected child abuse or neglect. Mandated reporters who fail to report suspected child abuse or neglect, within 72 hours of first suspicion, can be charged with a misdemeanor. If found guilty, the fine is up to $500 for the first incident and from $100 to $1,000 for any subsequent incidents. All such incidents are referred to the local Commonwealth's attorney.

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WHEN TO REPORT?

Section 63.1-248.3 of the Code of Virginia requires that mandated reporters **immediately report** suspected abuse or neglect* to the local department of social services or to the Child Abuse and Neglect Hotline.

You need not prove that abuse or neglect has taken place; local departments of social services are responsible for making this determination.

* Refer to the section in this booklet on Indicators of Abuse and Neglect for help in determining suspicion of child maltreatment.

HOW TO REPORT?

When you suspect that a child is being abused or neglected, **you should immediately report your concern to the local department of social services in your community.** Local social services departments are open during daytime business hours and their telephone numbers are listed on page 106 of this booklet.

Reports can also be made to the Child Abuse and Neglect Hotline (1-800-552-7096), seven days a week, 24 hours a day.

When making a report, it is helpful to provide as much information as possible, **if known.** For example:

- the name, address, and telephone number of the child and parents or other person(s) responsible for the child's care;
- the child's birthdate or age, sex, and race;
- the names and ages of other persons who live with the child and their relationship to the child;
- whether or not there is a family member who can protect the child;
- the name, address, and telephone number of the suspected abuser and his/her relationship to the child;
- the nature and extent of the abuse/neglect, including any knowledge of prior maltreatment of the child or siblings;

- whether the child has a disability and the way in which the disability affects the child's functioning and care;
- any other pertinent information; and
- your name, address, and phone number.

You may report anonymously if you choose, but you are encouraged to give your name. This makes it possible for the child protective services (CPS) worker to contact you later if additional information is needed. Providing your name will also enable the CPS worker to inform you of the investigation outcome.

INFORMING THE PARENTS

As professional, you have a relationship with the child and/or parents; therefore, you may wish to advise the parents of the report to child protective services.

If you choose to inform the parents, it is important that you be honest. Often parents will respect you for your honesty even though they may disagree with the position you've taken. You might explain that you are required by law to report all cases of neglect or injury to children caused by questionable or other than accidental means. The law does not give you a choice about reporting.

Filing a report of suspected child abuse or neglect can be described as "making a referral to request help and services for the child and family." Parents need to know that their problems are not unique and they are not inherently "bad" parents. The intent of a report is to protect the child from further harm and to improve family relationships.

Reassure the parents of your continued professional availability and your belief in the intervention process.

continued

5

INFORMING THE PARENTS

continued

There may be some instances in which you will not want to inform the parents of your report to CPS. These instances include a situation where the child's safety would be jeopardized by the parents' knowing the child has disclosed information to you or a situation where a child is in imminent danger and you believe the parent might disappear with the child.

Before informing the parents about a report of suspected abuse or neglect, it may be helpful to discuss your decision with the local CPS worker.

WHAT IF YOU'RE NOT SURE?

You may consult with your local department of social services, child protective services unit, or with staff at the Child Abuse and Neglect Hotline.

If a child has shared information with you about abuse or neglect, this is enough for you to call. It is better to make your concerns known than to remain silent and possibly allow a child to remain unprotected.

WHAT IF THE ABUSE OCCURRED IN THE PAST?

Any case of suspected child abuse or neglect, **where the victim is under age 18,** must be reported even if the abuse/neglect occurred in the past. The child protective services worker will evaluate the situation to determine whether an investigation is warranted at the time of your report.

WHAT IF A REPORT OF SUSPECTED ABUSE OR NEGLECT IS NOT ACCEPTED BY CHILD PROTECTIVE SERVICES?

Not all reports of suspected child abuse or neglect are accepted for investigation by child protective services (CPS).

When CPS decides not to investigate a report, it is usually due to the following: the report does not meet the legal definition of abuse/neglect; law enforcement has the responsibility to investigate; or the family's problems can be more effectively addressed by a different type of service.

You will be told whether or not the report will be investigated and the reasons why. If a decision is made not to investigate, and you disagree, you may further discuss your concerns with the CPS supervisor. When a case is not appropriate for CPS, you may ask for suggestions or guidance in working with the family.

FEEDBACK FROM CHILD PROTECTIVE SERVICES

Intrusion into family life to protect a child is a highly sensitive matter necessitating confidentiality. Due to strict federal and state laws concerning the release of child protective services (CPS) information, the CPS worker is restricted in the information that can be discussed with individuals outside of the family.

The CPS worker is permitted to give school employees information that is in the best interests of the child. At a minimum, you will be informed, in writing, that a report has been investigated and determined to be unfounded or that necessary action has been taken.

If you are not contacted by the CPS worker within 45-60 days of the date of the report and you wish to learn the outcome of the investigation or discuss any additional concerns, you may call the worker assigned to the case or the supervisor.

6

Issues and Concerns About Reporting

6

PERSONAL BIASES AND DIFFICULTIES WHICH MAY BE ENCOUNTERED WHEN REPORTING

A report of suspected maltreatment is not an accusation. It is a request for child safety assessment and needed services. The reporting process, however, may not always go smoothly. Difficulties may be encountered which can act as a barrier to reporting or can discourage continued involvement in situations of child abuse and neglect.

PREVIOUS EXPERIENCES

Professionals who have had an unsatisfactory experience when reporting suspected child abuse or neglect may be reluctant to report a second time. These professionals may have been discouraged from reporting, or may have developed a distrust of child protective services (CPS), feeling that a previous case was not handled to their satisfaction. These concerns are real. Things may not have gone as well as they could have. A previous bad experience, however, does not mean that the next time things will not be handled well. If you have an unsatisfactory experience with a CPS response, you should consider requesting intervention by a supervisor in the handling of the case.

Educators and law enforcement officers must report regardless of their concerns or previous experience. The law requires it and no exemptions are made for those who have had a bad experience. In addition, while reporting does not guarantee that the situation will improve, not reporting guarantees that if abuse or neglect exists, the child will continue to be at risk.

THE BELIEF THAT NOTHING WILL BE DONE

Sometimes potential reporters are convinced that nothing will be done if they report, so they don't report. Aside from the legal considerations (failure to report is illegal in Virginia), such reasoning is faulty. **If an incident of suspected child abuse or neglect is reported, some action will occur.** At the very least, reporting ensures that the department of social services is made aware of your concerns and your legal obligation is fulfilled. **On the other hand, if the incident is not reported, nothing will be done. Abused and neglected children cannot be protected unless they are first identified. The key to identification is reporting.**

CONFIDENTIALITY

IDENTITY OF REPORTERS

The identity of all persons who report suspected child abuse or neglect is confidential; however, in some instances, despite the child protective services worker's efforts to maintain confidentiality, families may be able to deduce the identity of the reporter. If the case is brought into court, the identity of the reporter may be revealed during court proceedings.

CARETAKER RIGHTS TO ACCESS CHILD ABUSE OR NEGLECT RECORDS

Any individual, including the alleged abuser or neglector, may exercise his/her rights under the Virginia Privacy Protection Act of 1976 and may demand to see all personal information, **related to him/herself,** contained in the case records.

The individual requesting information is given access to that portion of the record concerning him/herself, with safeguards taken to ensure the privacy rights of the other persons, including the reporter, mentioned in the case record.

7

Special Educator Response to the Child Victim

7

HOW TO RESPOND TO THE CHILD WHO REPORTS ABUSE/NEGLECT

When a child tells you, openly or indirectly, about abuse or neglect in his/her family, it is important to recognize the strength which this child has demonstrated by sharing his/her secret and to honor the trust shown by choosing you as a confidant.

Although it may be a difficult subject for you to discuss, it is important that you handle the disclosure with sensitivity. In part, this can be accomplished by following some general guidelines:

- **Listen to what is being told to you.** Do not push the child to share more than he/she is willing. The child needs warmth and acceptance. It is not necessary at this time that intimate details be revealed.

- **Reassure the child that he/she has done the right thing by telling you.** Acknowledge the difficulty of the decision and the personal strength shown in making this decision. Make it clear that the abuse or neglect is not the child's fault and that he/she is not bad or to blame.

- **Keep your own feelings under control.** Be calm and nonjudgmental. Be careful not to criticize or belittle the child's family.

- **Use the child's own vocabulary.**

- **Do not promise not to tell.** Know your limits. This is not a situation you can handle by yourself.

- **Tell the truth.** Don't make promises you can't keep, particularly relating to secrecy, court involvement, placement, and social worker decisions.

- **Be specific.** Let the child know exactly what is going to happen. Tell the child that you must report the abuse or neglect to child protective services. Tell the child that a social worker who helps families with these kinds of problems may be coming to talk with him/her.

- **Assess the child's immediate safety.** Is he/she in immediate physical danger? Is it a crisis? Are there others in the home who can protect the child?

- **Be supportive.** Remember why the child came to you. He/she needs your help, support, and guidance. Let the child know that telling about the abuse or neglect was the right thing to do. It is the only way to make it stop.

- **Try to help the child regain control.** The child is about to become involved in a process in which the primary intent will be to determine his/her best interest. At times, this may seem to sweep the child up in a series of events that are beyond his/her control. Although alternatives may be limited, it can help to let the child make decisions, whenever possible, to allow him/her some sense of self-determination. For example, you might ask the child what you can do to help or make the process less difficult.

TECHNIQUES FOR INTERACTING WITH THE ABUSED/NEGLECTED CHILD

The following are tools or techniques that can be used by educators with children who report abuse or neglect:

- never underestimate the power that a positive adult relationship can have in a child's life. Children take their cues from adults.
- make your classroom as safe as it can be. Structure and routine can help children regain a sense of personal control.
- ask permission before touching, again allowing a child to regain control.
- don't speak badly of the offender. The offender is often known and liked or loved by the child. Suggested statements are:

  "What he/she did to you was wrong—I am sorry that it happened to you."
  or
  "It was unfair of him/her to do that to you. I am sorry that it happened."

- try not to act shocked, angry, or upset at what a child may say or do. Remain open for more information. Suggested statements are:

  "I'm wondering where you learned that."

  "I'm wondering who taught you how to do that."

  "I'm sorry that happened to you. We need to tell someone so that (name) can get help to stop doing that to you."

- do not make a child feel different or singled out. Treat him/her just like every other child, but with an extra dose of compassion.

Utilize your colleagues as resource people and for support, **keeping in mind the child's right to privacy.**

8

Child Protective Services Investigation and Response

8

WHAT HAPPENS AFTER YOU MAKE A REPORT?

When a report of suspected child abuse or neglect is made, social services staff must determine that the situation described meets the legal definition of child abuse or neglect and whether child protective services (CPS) has the authority and responsibility to investigate.

After a report is accepted for investigation, the CPS worker gathers as much information as possible concerning the circumstances related to the reported incident. He/she interviews the child, the siblings, the parents or caretakers, the alleged abuser, and any other persons including allied professionals, having information about the incident. The CPS worker also observes the child's environment and location of the incident. In some instances, a law enforcement officer **may** accompany the CPS worker during the investigation for reasons of safety and/or to determine if criminal charges should be filed.

Through interviews, observation, and information gathering, the CPS worker will, within 45 days*, make one of two findings:

- **Founded:** The investigation reveals by a preponderance of evidence that abuse or neglect has occurred.
- **Unfounded:** The investigation reveals no evidence of abuse or neglect.

* In some cases, findings may be extended to 60 days.

RIGHT TO APPEAL INVESTIGATION FINDINGS

Any person who has a "founded" disposition made about him/her as a result of a child protective services investigation has a right to appeal. There are three levels of appeal. They include:

- a conference with the local department of social services director or designee;
- a state level administrative hearing convened before a hearing officer; and
- a judicial review before the local circuit court.

SERVICES PROVIDED TO THE FAMILY

Subsequent to conducting an investigation, the child protective services (CPS) worker is also responsible for providing or arranging for services designed to help the parents meet their child's developmental needs and reduce the likelihood of recurrence of maltreatment.

Services provided are community based and interdisciplinary in nature. Services **may** include individual and/or family counseling; parenting groups or classes; homemaker services; substance abuse treatment; respite day care; or family supervision, provided through home visits, by the CPS worker.

The length of time that CPS provides services to a family varies from case to case and is dependent on the continued risk of harm to the child.

REMOVAL FROM THE HOME AND PLACEMENT

Pursuant to federal and state statutes, child protective services (CPS) is required to try to make reasonable efforts to maintain family integrity and provide for the safety of the child in his/her own home. If for the child's safety, it becomes necessary to separate the family, it is preferable that the alleged abuser/neglector leave the home.

If it becomes necessary to remove the child, the CPS worker will give the parents or guardian an opportunity to place the child with relatives in order to preserve a sense of family identity. When this is not possible, placement in foster care or in group care may be necessary. **The ultimate goal is to reunite the family as soon as it is safe for the child.**

8

PROTECTIVE CUSTODY

When there is immediate danger to a child's well-being, Section 63.1-248.3 of the Code of Virginia permits law enforcement, child protective services (CPS), or physicians to take a child into protective custody for up to 72 hours without a court order.

Immediately after a child is taken into protective custody, the parents or guardians must be notified that the child is in custody. A report must be made to CPS so that an investigation can be conducted. The Juvenile and Domestic Relations Court also must be notified.

PHOTOGRAPHS AND X-RAYS

Section 63.1-248.3 of the Code of Virginia allows the child protective services worker to take photographs and arrange for x-rays of the child, as part of a medical evaluation, without the consent of the parent or guardian.

CIVIL COURT ACTION AND TESTIMONY BY SCHOOL EMPLOYEES

Most cases of child abuse or neglect do not require court involvement. Most families do not neglect or injure a child with willful intent, and will accept help in correcting the circumstances which caused the maltreatment. However, where there is evidence of abuse or neglect and the family does not do what is necessary to ensure the safety of the child, a petition may be filed in civil court by child protective services.

The court is a place where the rights of the child and the parents are protected. Ultimately, the court will decide what is in the best interests of the child and whether the family needs protective services.

School employees may be requested to provide written reports or testimony to assist the court in making a decision. Submitting written reports **may** eliminate or reduce the amount of time spent in judicial proceedings.

In those rare instances where school employees are called to testify, you will testify either as a factual witness or an expert witness. If you are a factual witness, you will be asked questions related to what you observed and your conversations with the child. If you are an expert witness, you will be requested to give a professional explanation regarding the child's disability.

CRIMINAL PROSECUTION

Child protective services is required to report certain cases of suspected child abuse or neglect to the local Commonwealth's attorney. These cases include:

- child death;
- injury or threatened injury involving a felony or Class 1 misdemeanor;
- any suspected sexual abuse, sexual exploitation, or molestation offense;
- child abduction; and
- any felony or Class 1 misdemeanor drug offense involving a child; or contributing to the delinquency of a minor.

Criminal prosecution is at the sole discretion of the local Commonwealth's attorney.

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Disabilities, Maltreatment, and Interdisciplinary Collaboration

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INTERDISCIPLINARY TEAMWORK

Interviewing a child with a disability about suspected child abuse or neglect can be a challenge due to the subject matter, diversity of disabilities, and the number of professionals involved with the child. Interdisciplinary collaboration among disabilities professionals, law enforcement, and child protective services workers will:

- capitalize on each professional's expertise;
- allow for the identification of common goals;
- minimize duplication of efforts and the risk that the activities of one investigation will interfere with the other; and
- minimize unnecessary confrontations that can deplete energy and resources of the child, family, and professionals.

Investigation of suspected abuse or neglect of children with disabilities should follow the same thorough investigatory principals as required for children without disabilities (Sobsey, 1994). The major investigatory responsibilities include:

- determining if maltreatment has occurred;
- protecting the child from further abuse/neglect;
- minimizing trauma to the child as a result of system intervention;
- determining whether a crime has been committed; and
- providing or arranging for needed services.

Investigation strategies to help facilitate interdisciplinary teamwork and effective intervention include:

- Specialized knowledge on the part of the law enforcement investigator and child protective services worker about children with disabilities;
- Assistance from a disability specialist either in interviewing or providing advice on how to conduct the interview or interpret the results; and
- Interdisciplinary policies and procedures on the management of suspected abuse or neglect of children with disabilities, including identified, trained agency liaisons.

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PRE-INTERVIEW PLANNING

Effective interviewing of a child with a disability requires that preliminary information be obtained from records* or other professionals/ persons knowledgeable about the child. Needed preliminary information includes (Crocker 1994):

- The child's **primary disability. Characteristics of a disability are on a continuum varying in degree from mild to severe with each child being unique in terms of his/her management of the disability.**
- **The way in which the disability impacts upon the child's current functioning** including cognition, language and communication mode, memory, mobility, emotions, behavior, self-care, and relationships. Ask how the disability affects the child's level of independence and need for assistance.
- **Any accompanying impairments,** e.g., visual, language, cognitive, or mental illness.
- **Communication challenges** including marked differences in receptive vs. expressive communication and use of augmented communication methods.
- **Behavior challenges** that may affect the interview and require management.
- **Distractibility** which may be addressed by control of stimuli in the interview setting.
- **Where the child receives treatment or special schooling related to the disability.** This is a prime source of additional information about the child's needs and a resource to the interviewer for management of the interview.
- **Special care needed as a result of the disability.** This may also give you information about the challenges for the family as a result of the disability.

It is also important to consider vulnerabilities by asking about (Crocker, 1994):

- behavioral compliance that has been historically rewarded;
- training/education in sexuality and/or self-protection;
- interpersonal dependency;
- other family stressors unrelated to the child's disability;
- availability of needed family resources; and
- individual or systemic isolation.

* Refer to the following section on Release of Records to Child Protective Services.

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RELEASE OF RECORDS TO CHILD PROTECTIVE SERVICES

During the course of a child abuse or neglect investigation, the child protective services (CPS) worker may request the release of school records.

Section 63.1- 248.3 of the Code of Virginia authorizes schools to release any records or reports which document the basis for the report of suspected abuse or neglect. School employees are responsible for determining which records or reports are necessary for release to CPS.

School reports that are contained in CPS records may not be released without authorization from the sending school, except to the Commonwealth's attorney, a CPS hearings officer, or a court determining an issue arising from a child abuse or neglect complaint.

INTERVIEWING CHILDREN IN SCHOOL

During an investigation, the child protective services (CPS) worker may request to interview the child victim and/or siblings at school. **Consent of the parent or guardian to interview at school is not necessary pursuant to Section 63.1-248.10 of the Code of Virginia.**

When there is reported maltreatment by a family member, the school setting can provide a safe environment away from the alleged abuser and site of the abuse. This neutral setting may lessen the child's anxiety, making it easier for him or her to talk. The decision to include school staff in the interview rests with the CPS worker and is based upon the best interests of the child, his or her right to privacy, and CPS need for interviewing assistance, especially with children who have language or communication challenges.

When interviewing a child with a disability, it is important to accommodate the child's special needs by choosing a room that is:

- accessible;
- familiar to the child; (An unfamiliar setting may be threatening to the child or cause distractions.)
- comfortable and suitable for children;
- quiet, with limited noise and distractions;
- close to an accessible restroom; and
- private.

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Frequent breaks may be necessary to accommodate the child's age, level of concentration, and other needs.

When interviewing children who use wheelchairs, canes, or other aids, it is important to sit at eye level; respect the child's sense of personal space by asking permission to touch the assistive device; and provide assistance with mobility only when needed and with permission from the child.

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INTERVIEW PRINCIPLES AND USE OF LANGUAGE

When interviewing any child about suspected abuse or neglect, including a child with a disability, the interviewer should be:

- **sensitive** to the child's developmental level;
- **flexible** in following the child's lead rather than adhering to rigid protocols;
- **objective** and nonjudgmental; and
- **empathetic.**

At the beginning of the interview, it is important for the interviewer to:

- explain the purpose of the interview and his/her role;
- establish a positive rapport; and
- provide a series of questions that are "neutral" in content to determine whether the child really understands or if additional adaptations need to be made.

  If the child is deaf or deafblind, and his/her primary mode of communication is sign language, a certified interpreter should be present to facilitate communication.

General questions, used to develop rapport and check the child's understanding, might include inquiries about: where the child lives; child's age or birth date; names and ages of siblings; name of school or teacher; favorite television show; likes and dislikes; and what the child did for fun this week (who, what, when).

The limits on confidentiality should be addressed early in the interview as most children worry about whom you will tell and why.

When exchanging information, simplify language by using:

- simple words;
- short sentences and questions;
- simple tenses;
- concrete, visual references; and
- focused questions, i.e., "who," "what," "when," "where."

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Common language pitfalls to avoid in the interview include (U.S. Department of Health and Human Services, 1993):

- Abstract words.
- Use of pronouns. Proper names are preferable.
- Complex questions with multiple ideas.
- Unclear references, e.g., those things, this, it, that. Repeat the name of the person or thing you are talking about.
- Yes/no questions. The child may answer affirmatively, believing a positive response is desired.
- Negative questions, e.g., "Didn't you go to the store?"
- Questions of relativity which require a high level of thinking, e.g., shorter, bigger, easiest, etc. When needing to use terms of relativity, use concrete examples, e.g., "Was it larger than the table over there?"
- "Why" questions.
- Leading questions, in which the desired answer is specified in the question.

All interviews should have closure, the purpose of which is to:

- Thank the child for his or her help. Praise the child's effort, not the content of what was said.
- Tell him or her what will happen next.
- Educate the child regarding personal safety.
- Explore safety options with the child (U.S. Department of Health and Human Services, 1993).

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INTERVIEWING CHILDREN WITH LANGUAGE/COMMUNICATION CHALLENGES

Some children with disabilities have language or communication difficulties that are challenging during the interview. Understanding the way(s) in which the disability affects the processing of information, so that needed adaptations can be made, is essential to a successful interview.

The information processing model divides communication into three stages (Crocker, 1994):

- **input** or the ability to receive information;
- **processing** or the ability to make sense of information; and
- **output** or the ability to communicate information back to the other person.

If a child has a disability, communication can be disrupted at any or all of these points. **The effect is often cumulative.** For example, problems with processing information will affect output. Input challenges affect the processing and output of information, disrupting all three areas of communication.

Disability types, related communication challenges, and needed interview adaptations are described below (Crocker, 1994).

INPUT CHALLENGES
(Visual, auditory, and tactile information)

Disability
- Blind/Visual Impairment
- Deaf/Hard of Hearing
- Learning Disabilities
- Epilepsy
- Tactile Sensory Impairment
- Deafblind or Dual Sensory Impairment

Adaptations
- Sit at same level
- Use normal voice tones
- Speak clearly
- Slower pace and repetition may be needed
- Eye contact is critical
- Written messages and visual aids
- Use of an interpreter
- Body language and facial expressions are important
- Quiet setting with limited noise and limited distractions
- Good lighting
- Tactile aids

PROCESSING CHALLENGES
(Information storage, retrieval, and understanding)

Disability
- Emotional Disturbance
- Learning Disabilities
- Mental Retardation
- Autism
- Traumatic Brain Injury
- Cerebral Palsy

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Adaptations

- Provide structure
- Minimize distractions
- Concrete language
- Developmental age-appropriate language
- Break down complex ideas
- Focused questions
- Questioning within contexts
- Speak distinctly
- Check for understanding
- Keep interviews short, may need multiple interviews
- Quiet setting with limited noise and limited distractions

OUTPUT CHALLENGES
(Vocal and motor information)

Disability

- Speech and language
- Deaf/hard of hearing
- Learning Disability
- Cerebral Palsy
- Traumatic Brain Injury
- Dual Sensory Impairment or Deafblind

Adaptations

- Sit at the same level
- Interpreter may be needed
- Listen carefully
- Watch body language
- Drawing boards
- Props may be needed
- Multiple modalities needed
- Quiet setting with limited noise and limited distractions
- Good lighting

IT IS IMPORTANT NOT TO CONFUSE COMMUNICATION DIFFICULTIES WITH A LACK OF INTELLIGENCE. It is also important not to confuse expressive communication ability with receptive communication abilities. Some children can understand more advanced language than they can produce on their own (Crocker, 1994).

Interviewing a child with a disability is not an easy task especially when there are language/communication challenges. The diversity of disabilities necessitates adaptation of the interview, including the language used by the interviewer, to the age, cognitive functioning, developmental level, and abilities of the child.

Collaboration, including interviewing assistance or advice from a disabilities professional knowledgeable about the child, will help the investigator to understand the disability, facilitate communication, validate impressions, and determine the need for protective intervention.

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USE OF INTERPRETERS

In those instances where the child is deaf, hard of hearing, or deafblind a certified interpreter is needed to facilitate the investigative interview. Use of a hearing friend, family member, or relative of the hearing impaired child, who knows sign language, is not recommended for confidentiality reasons, possible biases, and issues of competency.

A qualified professional interpreter must be considered and can be obtained through the Virginia Department for the Deaf and Hard of Hearing at 1-800-552-7917. Compensation for the interpreter is the responsibility of the interviewer.

The role of the interpreter is to facilitate communication by translating spoken English into Sign Language or Cued Speech and vice versa. **The interpreter is not part of the conversation.** He or she may not advise the interviewer or the child on what to say or how to say it, offer explanations or background information. A summary of what is said or signed is not acceptable (Virginia Department for the Deaf and Hard of Hearing, 1993).

All information discussed in the presence of the interpreter is confidential.

Prior to the interview, the interviewer should:

- discuss fees for interpreter services;
- describe the child's limitations, skills, and strengths;
- clarify roles and expectations with the interpreter; and
- outline the areas to be covered so that the interpreter can be prepared with suitable vocabulary. The interviewer and interpreter should also agree on the length and frequency of rest periods. Long sessions of signing can be tiring.

The interpreter should also be allowed time to talk with the child to determine what method of signing is most satisfactory and whether or not his or her interpreting skills are suitable to the child's needs.

In those instances where the child's sign language base is limited, i.e. he/she relies upon gestures or signing that is unique to their home environment, it may be necessary to have an interpreter who is deaf (native signer) along with a hearing interpreter, in order to facilitate accurate communication (Virginia Department for the Visually Handicapped, 1998).

Interview Strategies

- Begin the interview by developing positive rapport with the child through the use of general questions prior to focusing on the incident in question.
- The interviewer should look at the child, not at the interpreter.
- The interviewer should not speak or direct conversation to the interpreter.
- The interviewer should use the words "I" and "you" instead of "tell her" or "does he/she understand."
- Speak clearly and in normal tones. If you tend to talk quickly, slow down.
- Do not interrupt one another. The interpreter can interpret the message of only one person at a time.
- Allow time for the child to obtain all the information and to respond. The interpreter will be a few words behind the speaker in transferring information (Virginia Department for the Deaf and Hard of Hearing, 1993).

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FACILITATED COMMUNICATION

Facilitated communication is a process that provides physical assistance, through guidance of the hand or arm of a person with autism, cerebral palsy, or other developmental disability while that person types messages on a computer, typewriter, or other similar device (Sobsey, 1994).

Although facilitated communication has been demonstrated to be a valid form of communication, use of facilitated communication in child abuse and neglect investigative interviews remains controversial due to questions concerning possible influence of the facilitator. For this reason, attempts should be made to corroborate disclosures of abuse or neglect made through facilitated communication with other evidence (Sobsey, 1994).

COMPETENCY

While determining competency is one of the primary tasks of the court, often during the course of the investigation, law enforcement considers whether the child will make a competent witness. Social beliefs and misconceptions about persons with disabilities can influence one's perception of the competency of a child with a disability.*

"It has often been implied that young children and people with developmental disabilities are inappropriate as witnesses because they have poor memories and can easily develop false memories through the process of suggestion. Research shows that people with mental retardation typically recall fewer details of events than people without disabilities, but it does not suggest that they are more likely to fabricate false memories or distort what they do recall. In fact, people with mental retardation are probably less likely to fabricate believable lies because this requires sophisticated abstract reasoning skills" (Sobsey, 1994).

Some people with disabilities have particular difficulty with dates and times and even the sequencing of events, but they know what happened and who did it (Sobsey, 1994). Other people have communication challenges that must not be construed as a lack of intelligence or incompetence.

* Refer to the section in this booklet on Beliefs and Misconceptions about Children with Disabilities.

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"Perceived lack of competence on the part of the child with a disability has as much to do with the interviewing skill of the adult as it does with the child's ability to remember and accurately relate their experiences. Accuracy and credibility deteriorate as communication breaks down, not necessarily because the child is fabricating his/her responses or reporting fantasies, but, because of adult unfamiliarity with the disability and its affect on communication. Ultimately, communication failures between the adult interviewer and child victim can obscure the fact-finding process and derail the course of justice with cases dismissed because of concerns over the child's competency and credibility" (Saywitz, Nathanson, & Snyder, 1993).

Effective communication during the investigation and in the courtroom is essential for credible evidence to emerge. The child's ability to communicate what happened is influenced by:

- the adult interviewer's ability to talk to the child, using language and concepts that he/she can understand;
- the child's developmental stage including age, cognition, vocabulary, linguistic skill, and emotional functioning; and
- the child's understanding of the investigative and judicial process (Saywitz, Nathanson, & Snyder, 1993).

"To a child, the investigatory process and the language and procedures of the courtroom resemble a foreign culture and language. Most children do not have a context for understanding the needs of the various people, their functions, or the rules by which people interact in the legal setting. Their misunderstandings can ultimately compromise credibility" (Saywitz, Nathanson, & Snyder, 1993). Thorough preparation and familiarity with the physical environment of the courtroom, the procedures, and persons present, in addition to needed courtroom accommodations, will facilitate an optimal environment for the child to accurately tell what they know.

The presence of a physical, developmental, or emotional disability or difficulty with communication does not automatically render a child incompetent to testify. It is the responsibility of investigators to facilitate communication by obtaining assistance or advice from a disabilities professional knowledgeable about the child and/or a certified interpreter. The use of disability experts will:

- help the investigator to understand the disability and its impact on the child's functioning and communication;
- validate impressions;
- make charging decisions in collaboration with the prosecutor; and
- assist the court in understanding the evidence.

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Child Abuse and Neglect Prevention

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PREVENTION STRATEGIES

The goal of prevention is to intervene **before** abuse and neglect occur. Child abuse and neglect prevention strategies for children with disabilities are multifaceted and can include:

- identification and early intervention services for high risk families;
- support services for families of children with disabilities who are experiencing stress;
- educational programs that teach children with disabilities personal safety skills and related issues on human sexuality;
- information for parents and direct care providers on child safety and identification and reporting of suspected abuse and neglect;
- criminal records checks and child abuse and neglect background checks, as part of a thorough pre-employment screening of direct care providers; and
- **residential care safeguards that include** (Sobsey, 1994):
  - clear child abuse/neglect policies and procedures with associated staff training;
  - required reporting of abuse and neglect, within the facility, and protection for staff and residents who report;
  - non-aversive behavior management strategies;
  - training in non-violent, self defense strategies for staff working with aggressive residents;
  - realistic staff expectations;
  - supervisory leadership that models and rewards good care giving;
  - administrative efforts to enhance job satisfaction for staff providing direct services;
  - good communication and teamwork within the facility;
  - available employee counseling and staff support programs;
  - cultivation of positive attitudes about people with disabilities;
  - emphasis on inclusion versus segregation and isolation of residents; and
  - recognition that residents are service consumers.

Programs and services for children with disabilities that are well integrated into the larger community will encourage interaction, thereby reducing the risks associated with personal and program isolation (Sobsey, 1994).

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PREVENTION CURRICULUM COMPONENTS

Since many interrelated factors place children with disabilities at increased risk for abuse, an eclectic approach that educates and empowers children and changes the social and environmental conditions that foster abuse is necessary for successful risk reduction.

The basic contents of abuse prevention education programs for children with disabilities are the same as for children without disabilities. These include (Sobsey, 1994):

- personal safety skills training and related issues on human sexuality;
- education about individual rights;
- assertiveness and self-esteem training;
- communication skills training; and
- social skills training.

Since children with disabilities exhibit a broad range of learning styles and skills, child abuse prevention programs must be adapted to meet their individual needs.*

* See the appendix for child abuse prevention resources and curricula which can be used or adapted to meet the needs of children with disabilities.

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Appendix

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GLOSSARY OF DISABILITIES*

ATTENTION DEFICIT / HYPERACTIVITY DISORDER (AD/HD)

A neurobiological disorder characterized by developmentally inappropriate behavior, poor attention skills, impulsivity, and hyperactivity. These characteristics typically arise before age seven, are chronic, and last at least six months.

The exact cause of AD/HD is unknown, although, scientific evidence suggests it is genetically transmitted and may result from a chemical imbalance/deficiency in the brain. It is not caused by factors in a child's environment.

Impact on Functioning

- **Hyperactivity.** High activity levels not connected with a specific situation or stimulus. Child may be fidgety, have difficulty sitting still or playing quietly, and talk excessively.
- **Impulsivity.** Acts before thinking, frequently interrupts others, difficulty awaiting turn, and may not assess danger before acting.
- **Inattention.** Child has difficulty sustaining attention in tasks or play; seems not to listen; is easily distracted by extraneous stimuli; fails to give close attention to details, often making careless mistakes in schoolwork or other activities; and often has difficulty following through on instructions.

Many children with AD/HD have great difficulty in school where attention and impulse and motor control are necessary for academic success. They often have difficulty with social skills and self-esteem.

Child and Family Issues

- Child may need medication.
- Child may resist taking medication because it makes them feel "different."
- Medication must be monitored for side effects by a pediatrician.
- Counseling is often recommended to assist parents in behavior management techniques.

* National Information Center for Children and Youth with Disabilities (NICHCY)
Virginia Institute for Social Services Training Activities (VISSTA), Virginia Commonwealth University

AUTISM: PERVASIVE DEVELOPMENTAL DISORDER (PDD)

A neurological disorder, usually evident by age three, that affects a child's ability to communicate, understand language, play, and relate to others. The cause is unknown and not due to psychological factors.

Impact on Functioning

Children vary widely in abilities, intelligence, and behaviors, but, may exhibit several of the following characteristics:

- Impaired attachment i.e. unaware of others or abnormal way of relating, delayed or absent smiling and eye contact, touch avoidance, solitary play.
- Communication problems i.e. understanding and using language, speech delays, pronoun reversal, echolatia, rhyming.
- Difficulty understanding abstract concepts.
- Unusual play with objects; may avoid or be preoccupied with them, spin them.
- Difficulty with changes in routine and environment.
- Repetitive body movements or behavior patterns.
- Unusual responses to sensory information, e.g., loud noises, lights, certain food or fabric textures.

Child and Family Issues

- Parents may be sleep deprived because many children with autism/PDD have difficulty sleeping.
- Carry over of skills learned at school to home is important.
- Interaction with non-disabled peers is important to provide modeling of appropriate language, social, and behavior skills.
- Respite, support groups, and counseling may be needed.
- Parents need to educate themselves regarding the latest treatments.
- Close collaboration with the school is important to facilitate goal setting and intervention.

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GLOSSARY OF DISABILITIES*

CEREBRAL PALSY

A chronic condition caused by damage to the brain usually before, during, or following birth. "Cerebral" refers to brain and "palsy" to a disorder of movement or posture. It is not progressive. Symptoms can range from mild to severe.

There are three main types of cerebral palsy:

- **Spastic** Stiff and difficult movement;
- **Athetoid** Involuntary and uncontrolled movement; and
- **Ataxic** Disturbed sense of balance and depth perception.

Impact on Functioning

- Inability to fully control motor function which may include spasms; tonal problems; involuntary movement; disturbance in gait and mobility; seizures; abnormal sensation and perception.
- Mental retardation **may** be present.
- Impairment of sight, hearing, or speech **may** be present.
- Learning, social, and personal problems **may** develop as a result of the disability and/or attitudes of others.

Child and Family Issues

- Early identification and intervention to maximize functioning.
- Education/training of family members on meeting the needs of the child with cerebral palsy.
- Respite, support groups, and counseling may be needed.
- Adaptive aids and equipment may be needed for educational and daily living experiences.
- Assistive technology such as computers and augmentive/alternative communication devices may be needed.
- Opportunities for community integration and recreation are important to the development of a sense of well-being.

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Virginia Institute for Social Services Training Activities (VISSTA), Virginia Commonwealth University

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DEAFNESS AND HEARING IMPAIRMENT

A person who is hearing impaired is required to process information totally or partially through a sensory channel other than hearing. Hearing impairments range from slight to profound and include:

- **Deaf** Non-functional hearing for everyday purposes.
- **Congenitally deaf** Born deaf.
- **Adventitiously deaf** Born with normal hearing but became deaf later as a result of illness.
- **Hard of Hearing** Impaired, but functional, hearing.

Hearing impairments are characterized by difficulty in producing the spoken language and/or an inability to understand auditory information.

Hearing loss or deafness does not affect a person's intellectual capacity or ability to learn.

Impact on Functioning

The impact on functioning depends on:

- the extent and type of hearing loss;
- age of onset;
- age when remediation began;
- degree of intelligence of the child; and
- quality of instruction the child has received.

Child and Family Issues

- Child is more susceptible to social difficulties and needs opportunities for socialization.
- Family members need to attend auditory training program to learn communication techniques and skills.
- Counseling and support groups may be needed during adjustment period.
- Close collaboration with the school system is important to meeting the child's needs.
- Parents need to be made aware of the deaf culture. Parents may feel conflicted about either immersing their child in a "deaf culture" or including him/her in the "hearing world."

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GLOSSARY OF DISABILITIES*

DEAF/BLIND

Deaf/blind refers to a combination of vision and hearing problems which prevent the use of either vision or hearing as a primary source of learning and communication.

The combination of deafness and blindness is one of the most severe disabilities known. Persons with this dual disability face unique problems of communication and mobility that drastically curtail their sources of information. This disability often promotes an intense sense of isolation and loneliness (Smithdas).

Deafblind includes persons **who have no useful hearing and vision and persons who, although severely impaired, do obtain some information through residual hearing and/or vision as follows:**

- **deafblind** legal blindness and a severe to profound hearing loss;
- **blind and hard of hearing** legal blindness and a mild to moderate hearing loss;
- **deaf and visually impaired** profoundly deaf with some usable vision; and
- **visually impaired and hard of hearing** some usable vision and hearing (Virginia Department for the Visually Handicapped, 1998).

Methods of Communication

Children who are deafblind may use any one or a combination of the following communication methods:

- **sign language and fingerspelling:** whether visual or tactile is commonly used by deafblind persons who were born deaf. When using tactile sign language, the child places his/her hand on top of the signers hand for receptive communication.
- **restricted field signing:** all signing is done within the child's restricted field of vision i.e. within a very small space.
- **tracking:** the child holds the wrist or arm of the signer in order to place the signs within the child's best field of vision.
- **braille:** a system of touch reading that uses raised dots to represent the letter of the alphabet and numbers 0-9. Braille has two grade levels: Grade 1 and Grade 2.
- **auditory-oral speech:** used by persons who have sufficient residual hearing to hear and understand speech with the use of amplification and/or who can express themselves through speech.
- **gestures/home signs:** some children with no formal sign language skills rely on gestures or home signs for communication. If appropriate, it is essential that the person most familiar with the child's method of communication be consulted to assist with communication (Virginia Department for the Visually Handicapped, 1998).

* National Information Center for Children and Youth with Disabilities (NICHCY)
Virginia Institute for Social Services Training Activities (VISSTA), Virginia Commonwealth University

Impact on Functioning

The impact on functioning depends on:

- age of onset;
- the extent of loss of vision and hearing;
- degree of intelligence of child;
- child's communication skills;
- extent of isolation;
- orientation and mobility skills;
- social or interaction skills;
- dependency on others.

Child and Family Issues

- Family members may need training in their child's preferred mode of communication.
- Parents need to know how to help their child use any residual vision or hearing;
- Dependency on others increases risk of maltreatment.
- Child may be isolated and needs opportunities for socialization.
- Parents, teachers, and others need to know the proper way to get the child's attention, most often through touching the back of the hand or forearm.
- Parents may need guidance in helping their child to develop a positive self image.
- Parents may need counseling and support, especially if they blame themselves for their child's disability.

Best Practice In Child Abuse/Neglect Investigations

- **Listen** to the child whether he/she uses words, signs, pictures, gestures, or behaviors.
- Request assistance from a **qualified mental health counselor who is fluent in sign language.***
- If a qualified counselor is not available, request the assistance of a **certified interpreter** ** to assist with communication. In those instances where the child's sign language base is limited, i.e. he/she relies upon gestures or signing that is unique to their home environment, it may be necessary to have an interpreter who is deaf (native signer) along with a hearing interpreter, in order to facilitate accurate communication.
- For those children without usable vision, it may be necessary to work with anatomically correct dolls (Virginia Department for the Visually Handicapped, 1998).

* Contact the Office of Mental Health at the Department of Mental Health, Mental Retardation, and Substance Abuse Services at (804) 371- 2134 for a listing of qualified mental health counselors.

**Contact the Virginia Department for the Deaf and Hard of Hearing at 1-800-552-7917 for a listing of certified interpreters.

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GLOSSARY OF DISABILITIES*

DOWN SYNDROME

A condition, associated with mental retardation, caused by chromosomal abnormality that changes the orderly development of the body and brain. Some common characteristics include:

- Distinct physical appearance.
- Poor muscle tone.
- Physical and intellectual developmental delay.
- Mental impairment from mild to severe.
- Health related problems. Lower resistance to infection may lead to respiratory problems.
- Visual problems such as crossed eyes and far- or near-sightedness **may** be present.
- Mild to moderate hearing loss and speech difficulties **may** be present.

Impact on Functioning

There is a wide variation in mental abilities, behavior, and developmental progress in children with Down Syndrome. Research has shown that stimulation during early developmental stages improves the child's chance of developing to his or her full potential.

Child and Family Issues

- Parents may feel guilty about transmission of the disability.
- Parents may experience feelings of loss.
- Parents need to be educated on the disability and the child's specific needs.
- Parents need to provide appropriate and continuous stimulation and teach self-care skills.
- Early intervention services to maximize functioning.
- Child may be teased by peers and excluded from groups or activities.
- Child needs opportunities for inclusion in recreational, social, and other activities.
- Child may have an impaired sense autonomy; needs to practice making own decisions.
- Support groups may be needed.

* National Information Center for Children and Youth with Disabilities (NICHCY)
Virginia Institute for Social Services Training Activities (VISSTA), Virginia Commonwealth University

EMOTIONAL DISTURBANCE

A condition that, **over along period of time and to a marked degree,** adversely affects educational and life performance and is characterized by:

- an inability to learn that cannot be explained by intellectual, sensory, or health factors;
- an inability to build or maintain satisfactory interpersonal relationships with peers or teachers;
- inappropriate types of behavior or feelings under normal circumstances;
- a general pervasive mood of unhappiness or depression; and
- a tendency to develop physical symptoms or fears associated with personal or school problems.

The causes of emotional disturbance have not been adequately determined.

Impact on Functioning

The impact on functioning depends on the number and severity of symptoms including:

- **hyperactivity** (short attention span, impulsiveness);
- **aggression/self-injurious behavior** e.g. acting out, fighting;
- **withdrawal** (failure to initiate interaction or retreats from interactions with others, excessive fear or anxiety);
- **immaturity** (inappropriate crying, temper tantrums, poor coping skills); and
- **learning difficulties** (academic performance below grade level.)

Children with the most serious emotional disturbances may exhibit distorted thinking, excessive anxiety, bizarre motor acts, and abnormal mood swings. They are sometimes identified as having severe psychosis or schizophrenia.

Child and Family Issues

- Parent support groups and respite care may be needed.
- Education and counseling may be needed to assist parents with understanding and managing the child's behavior.
- Intensive case management and multi-agency coordination is needed.
- Close collaboration with the school system is important in goal setting and treatment.

11

GLOSSARY OF DISABILITIES*

EPILEPSY

A physical condition that occurs when there is a sudden, brief change in brain functioning. When brain cells are not working properly, a person's consciousness, movement, or actions may be altered for a short time. These physical changes are called epileptic seizures.

Seizures can be:

- **generalized.** All the brain cells are involved characterized by convulsions and complete loss of consciousness or brief periods of fixed staring.
- **partial.** Brain cells, not working properly, are limited to one part of the brain characterized by "automatic behavior" that seems purposeful, but is repetitive, unconscious, and usually not recalled, e.g., repeatedly buttoning or unbuttoning a shirt.

Epilepsy does not affect intellectual capacity.

It can be caused by head injury and diseases of the brain, e.g. meningitis. Children with mental retardation or cerebral palsy may also have some type of brain damage that produces epileptic seizures.

Impact on Functioning

Epilepsy is characterized by the following symptoms:

- blackouts or confused unintelligible sounds, confused memory;
- episodes of staring or unresponsiveness;
- involuntary movement of the arms or legs;
- "fainting spells" with incontinence are followed by fatigue; and
- "odd or confused, unintelligible sounds," distorted perceptions, episodic feelings of fear with no explanation.

Child and Family Issues

- Compliance with medication is important.
- Communication with the school concerning the medication plan.
- Attentiveness to changes in child's behavior and health, especially if the child is on medication with side effects.
- Parent training on handling seizures and general safety precautions.
- Continuance/discontinuance of typical childhood activities needs discussion.
- Overprotection by parents may develop. Independence and confidence needs to be encouraged with general precautions.
- Child may have feelings of anxiety regarding seizures.
- Child may be teased by peers.

* National Information Center for Children and Youth with Disabilities (NICHCY)
Virginia Institute for Social Services Training Activities (VISSTA), Virginia Commonwealth University

LEARNING DISABILITIES

A disorder in one or more of the basic psychological processes involved in understanding or using language, spoken or written, which manifests itself in an imperfect ability to listen, think, speak, read, write, spell, or do math calculations. Learning disabilities are characterized by a significant difference in the child's achievement in some areas, as compared to overall intelligence.

Learning disabilities do **not** include learning problems that are primarily the result of visual, hearing, or motor disabilities; mental retardation; or environmental, cultural, or economic disadvantage.

The exact cause is unknown, but most likely is related to subtle neurologic deficiencies or to genetically based lags in maturation.

Impact on Functioning

The impact on functioning varies according to the type of learning disability and degree of impairment of the learning process. Learning disabilities may occur in the following academic areas:

- **Spoken language:** Delays, disorders, or discrepancies in listening and speaking.
- **Written language:** Difficulties with reading, writing, and spelling.
- **Arithmetic:** Difficulty in performing arithmetic functions or in comprehending basic concepts.
- **Reasoning:** Difficulty in organizing and integrating thoughts.
- **Organization skills:** Difficulty in organizing all facets of learning.

Hyperactivity, inattention, and perceptual coordination problems may be associated with learning disabilities. Associated traits **may** include:

- uneven and unpredictable test performance;
- impulsiveness;
- low tolerance for frustration; and
- problems in handling day-to-day social interactions and situations.

Child and Family Issues

- Child may begin to feel "stupid" and inadequate.
- Parents may begin to doubt their own competencies or become impatient and frustrated with their child.
- Parents need to be educated on the specific disability and their child's needs.
- Close collaboration with the school is important in setting goals that build upon the child's unique learning style.

11

GLOSSARY OF DISABILITIES*

MENTAL RETARDATION

"Mental retardation refers to substantial limitations in present functioning. It is characterized by significantly sub-average intellectual functioning, existing concurrently with related limitations in two or more of the following adaptive skill areas:

- communication;
- self-care;
- home-living;
- social skills;
- community use;
- self-direction;
- health and safety;
- functional academics;
- leisure; and
- work" (American Association of Mental Retardation, 1992.)

Degrees of mental retardation range from mild to profound. People with mental retardation learn slowly and with difficulty, but they do learn. Mental retardation manifests before age 18.

Causes may include chromosomal abnormalities, asphyxia (lack of oxygen), blood incompatability between the mother and fetus, maternal infections such as rubella or herpes, and prenatal substance abuse.

Impact on Functioning

The impact on functioning depends on the degree of mental retardation and other factors such as early intervention services, school environment, family involvement, socioeconomic status, and the child's desire and motivation. With appropriate supports, over a sustained period, the life functioning of a person with mental retardation will generally improve.

Child and Family Issues

- Parents may feel guilty about transmission of the disability.
- Parents may experience feelings of loss.
- Denial or overprotection may occur during the parents' adjustment phase.
- Parents and siblings need to be educated on the disability and the child's specific needs.
- Early intervention services to maximize functioning.
- Parents need to provide appropriate and continuous stimulation and teach self-care skills.

* National Information Center for Children and Youth with Disabilities (NICHCY)
Virginia Institute for Social Services Training Activities (VISSTA), Virginia Commonwealth University

SEVERE AND/OR MULTIPLE DISABILITIES

People with severe disabilities are those who traditionally have been labeled as having severe to profound mental retardation. They frequently have additional disabilities including movement difficulties, sensory losses, and behavior problems. They require ongoing, extensive support in more than one major life activity.

Impact on Functioning

Children with severe or multiple disabilities may exhibit a wide range of characteristics depending upon the severity and combination of disabilities and the person's age. Characteristics may include:

- limited speech or communication;
- difficulty in basic physical mobility;
- tendency to forget skills through disuse;
- trouble generalizing a skill from one situation to another; and
- a need for support in major life activities including domestic, leisure, vocational, and community areas.

A variety of medical problems including seizures, sensory loss, hydrocephalus, and scoliosis **may** accompany severe disabilities.

Child and Family Issues

- Early intervention to maximize functioning.
- Adaptive aids and equipment may be needed for educational or daily living experiences.
- Assistive technology such as computers or augumentive/alternative communication devices may be needed.
- Parents need to be educated on their child's disabilities and needs.
- Parent support groups and respite care may be needed.
- Intensive case management and multi-agency coordination is needed.
- Close collaboration with the school system in goal setting and intervention.
- Child needs opportunities for inclusion in programs and activities with able-bodied peers to develop social skills and friendships.

11

GLOSSARY OF DISABILITIES*

SPEECH AND LANGUAGE DISORDERS

Speech and language disorders refer to problems in communication and related areas such as oral motor function. These delays and disorders range from simple sound substitutions to the inability to understand or use language or use the oral-motor mechanism for functional speech and feeding.

Speech disorders refer to difficulties producing speech sounds or problems with voice quality.

A language disorder is an impairment in the ability to understand and/or use words in context. Some characteristics of language disorders include:

- improper use of words and their meanings;
- inability to express ideas;
- inappropriate grammatical patterns;
- reduced vocabulary; and
- inability to follow directions.

One or a combination of these characteristics may occur in children who are affected by language learning disabilities or developmental language delay. Children may hear or see a word but not be able to understand its meaning. They may have trouble getting others to understand what they are trying to communicate.

Mental retardation and hearing loss predispose a child to speech impairment. Other causes include neurological disorders, brain injury, and physical impairments such a cleft lip or palate. Frequently, the cause is unknown.

Impact on Functioning

Failure to detect and treat at an early age or prolonged/continued impairment may affect the development of social relationships and emotional interactions and may increase difficulty in developing academic skills.

Child and Family Issues

- Child may be teased by peers.
- Parents may experience feelings of loss and frustration.
- Parents may deny the disability due to familiarity with the child's speech or a lack of information on normal speech development.
- Parent education on the child's disability, appropriate interventions, and communication techniques.
- Collaboration with the school system is important in goal setting.

* National Information Center for Children and Youth with Disabilities (NICHCY)
Virginia Institute for Social Services Training Activities (VISSTA), Virginia Commonwealth University

SPINA BIFIDA

Spina bifida means cleft spine, which is an incomplete closure in the spinal column. There are three types of spina bifida ranging from mild to severe including:

- **Spina bifida occulta.** There is an opening in one or more of the vertebra (bones) of the spinal column without damage to the spinal cord.
- **Meningocele.** The protective covering around the spinal cord has pushed out through the opening in the vertebra in a sac called the "meningocele." The spinal cord remains intact and the opening can be surgically repaired.
- **Myelomeningocele.** This is the most severe form of spina bifida characterized by a portion of the spinal cord protruding through the back. Sometimes the cord is covered with skin. In other cases, nerves and tissues are exposed. This type of spina bifida accounts for 96% of cases diagnosed.

Spina bifida results from failure of the spine to close properly during the first month of pregnancy.

Impact of Functioning

The effects of myelomeningocele may include:

- muscle weakness or paralysis below the area where the cleft occurs.
- loss of sensation below the cleft.
- loss of bowel and bladder control.
- fluid build up in the brain i.e. hydrocephalus which must be shunted to avoid brain damage, seizures, or blindness. (70-90% of children with myelomeningocele have hydrocephalus which can lead to attention and learning problems.)
- impaired mobility.

Child and Family Issues

- Parents may need counseling, respite care, or other supports.
- Trauma of multiple surgeries and separation for the child from home, school, and friends while hospitalized.
- Child needs to access multiple resources for medical, educational, physical, and occupational therapies.
- Intensive case management and multi-agency coordination is needed.
- Parent and child training on bladder/bowel control and mobility exercises.
- Child's emotional and social development may be affected.
- Child needs to be encouraged to be independent within the limits of safety and health.
- Child needs opportunities for inclusion in social and other activities with able bodied peers.

11

GLOSSARY OF DISABILITIES*

TRAUMATIC BRAIN INJURY (TBI)

Traumatic brain injury is defined as an acquired injury to the brain, caused by external physical force, resulting in functional disability and/or psychosocial impairment that adversely affects a child's educational performance.

Impairments can occur in cognition; language; memory; attention; reasoning; abstract thinking; judgement; problem solving; sensory, perceptual, and motor abilities; psychosocial behavior; physical functions; information processing; and speech.

The most frequent causes of traumatic brain injury are related to motor vehicle crashes, falls, sport injuries, and abuse/assault.

Impact on Functioning

Typically, children have no visible impairments after a head injury. Symptoms vary greatly depending upon the extent and location of the brain injury. They can be temporary or permanent and range from mild to severe including:

- **Physical impairments.** Speech; vision; hearing; headaches; lack of fine motor coordination; spasticity of muscles; paralysis on one or both sides; seizures; or balance and other gait impairments.
- **Cognitive impairments.** Short and long-term memory deficits; impaired concentration; slowness of thinking; limited attention span; and impairments of perception, communication, reading and writing skills, planning, sequencing, and judgement.
- **Psychosocial, behavioral, or emotional impairments.** Fatigue; mood swings; denial; self-centeredness; anxiety; depression; lowered self-esteem; restlessness; lack of motivation; inability to self-monitor; difficulty with emotional control, agitation, excessive laughing or crying; and difficulty relating to others.

Child and Family Issues

- Early identification and intervention to maximize functioning.
- Children with brain injuries can often remember how they were before the trauma, resulting in emotional and psychosocial problems not usually present in children with congenital difficulties.
- Attention is often focused on the child's disabilities after the injury which can reduce self-esteem.
- Family and friends recall what the child was like prior to injury and may have difficulty adjusting goals and expectations.
- The child may need to relearn material previously known.
- Opportunities for success, that build upon the child's strengths, are important.

* National Information Center for Children and Youth with Disabilities (NICHCY)
Virginia Institute for Social Services Training Activities (VISSTA), Virginia Commonwealth University

VISUAL IMPAIRMENTS

Visual impairment refers to various degrees of visual loss that cannot be corrected with regular prescription lenses and includes partially sighted, low vision, legally blind, and totally blind.

Impact on Functioning

The effect of visual problems on a child's development depends on the severity, type of loss, age at which the condition appears, and overall functional level of the child. Children with visual impairments may have:

- Gross motor skill development delays.
- Delayed language development, when words are initially paired with objects.
- Impaired understanding of commands.
- Impaired conceptual development in the areas of identification of objects and events, physical space concepts, spatial relationships, and numbers.
- Impaired social functioning due to an inability to understand nonverbal cues or imitate social behavior.
- Impaired expression of affect through facial expression.
- Possible impaired autonomy, self-esteem, and ability to talk to others.

Child and Family Issues

- Early identification and intervention to maximize functioning.
- Education and counseling may be needed to assist parents with understanding and managing the visual impairment.
- Close collaboration with the school system on their child's needs and goals.
- Parents need to provide a home environment that maximizes familiarity and security.
- For children with partial visual impairments, the recommendation to learn non-visual techniques (braille, audio tape, computer) may be met with resistance due to the child's desire to see self as "non-disabled."

11

CONTINUUM OF DISABILITIES*

TYPE OF DISABILITY	MILD	MODERATE	SEVERE
Autism/Pervasive Developmental Disorder	Limited range of interests, repetitive play skills, impaired social skills.	Significantly affected verbal and nonverbal interactions, limited range of interest, impaired social skill, difficulty with abstract concepts.	Repetitive movements, resistance to change in environment or routine as well as unusual responses to sensory experience, lack of verbal and nonverbal communications, behavioral disabilities.
Emotional Disturbance	Affective or adaptive behavior problems.	Significant affective or adaptive behavior problems, social problems.	Constitutes danger to themselves or others.
Cerebral Palsy	Inability to control motor function. Awkward gait.	Spastic, stiff and difficult movement, involuntary and uncontrolled movement, disturbed sense of balance and depth perception.	Spasms, tonal problems, involuntary movement, disturbance in gait and mobility, seizures, abnormal sensations and perception, impairment of sight, hearing, or speech, and mental retardation.
Speech & Language Disorders	Slurred speech, lisp or mild articulation problems which are not developmentally appropriate, inaccurate use of language, delays in responding.	Word finding problems, difficulty in using language systematically, hard to understand.	Significantly interferes with general living skills. Inability to use language to communicate needs or desires.
Blind/Visual Impairment	Near sighted, far sighted, color blind, astigmatism.	Need for glasses, use of a long cane, trained guide dogs. Tunnel vision, ability to see light/dark shadows and shapes. Partial field vision.	Total Blindness

*Illinois Joint Training Initiative, Institute on Disability and Human Development, University of Illinois at Chicago, 1996.

TYPE OF DISABILITY	MILD	MODERATE	SEVERE
Deaf/Hard of Hearing	Difficulty with faint or distant speech or speech in group situations. May result in delay in speech and language articulation, learning disability, and inattention.	May hear only loud speech; may be able to identify environmental sounds; may be able to discriminate vowels but not consonants, social problems, speech and oral language may not develop spontaneously.	Total Deafness
Tactile Sensory Impairment	Inability to distinguish types of touch (e.g., pressure vs. pain) on part of the body.	Partial loss over some or all of the body or total loss on part of the body.	No physical sensation at all.
Epilepsy	Brief periods of fixed staring.	Periods of automatic behavior and altered consciousness.	Convulsions with complete loss of consciousness.
Learning Disabilities	Processing deficits which mildly impacts on learning, can learn to compensate, mild social problems, difficulty in academics.	Significant processing deficits, under-achieving, major social problems.	Impacts significantly across all areas of learning and daily living.
Traumatic Brain Injury	Mild difficulties in sensory perception, motor movement, language skills, memory, or problem solving.	Mild difficulties across main areas or difficulty in one or more domains.	CP, paralysis, mental retardation, visual impairments, hearing impairments, speech impairments. Major secondary disability due to head trauma.

11

DEVELOPMENTAL LANGUAGE SKILLS**

AGE	SKILLS	EXAMPLE
2.6 - 3 Years*	Begins to use the "WH" questions to get information.	Usually obtained this order- What, Where, Why, When, and How.
	Understands some pronouns.	Me, him, your, my, they, he, she.
	Uses words in simple sentences.	I drink water.
	Understands quantity concepts.	Give me **three** blocks.
	Understands spatial concepts.	Put the ball **in** the box. Take the ball **out** of the box. Put the ball on **top** of the table.
	Identifies colors.	Red, orange, blue, etc.
	Understands quantity concepts.	Give me **all** the blocks. Give me **some** blocks.
	Can tell the purpose of basic objects.	You draw with a pencil. You cut with a knife.
	Understands descriptive concepts.	The box is **big.** The block is **small.**
	Understands actions in pictures.	Tell me what is happening in this picture.
	Can tell about remote events.	What do you do when you are hungry?
	Understands negatives.	Do **not** cross the street.

* There may be individual differences at each age level due to variation in the acquisition of language skills.

**Illinois Joint Training Initiative on Disability and Human Development, University of Illinois at Chicago. (1996). Abuse and Disability. Compiled from: Preschool Language Scale by the Psychological Corporation, Harcourt Brace Jovanovich Inc., 1991 & A Few Facts about Children's Learning Skills by Anne Graffam Walker, 1990.

AGE	SKILLS	EXAMPLE
3.6 - 5 Years*	Compares objects.	Which one is heavier?
	Can understand some time concepts.	Did you go in the **day** time?
	Can describe a procedure.	Tell me how to make a sandwich.
	Understands more complex directions.	Put the book in the red box that is open.
	Can define some simple words.	Tell me what a car is.
	Responds to "why" questions with a reason.	Tell me why you brush your teeth.
	Responds to "when" questions.	When do you eat breakfast?
	Can name categories.	Tell what these are: Dog, cat, pig, mouse.
	Identifies at least five basic body parts.	Where is your arm? etc.
	Understands descriptive concepts.	Look at those two people. Which one is short?
	Can identify an object.	Show me the fork on the table.

11

DEVELOPMENTAL LANGUAGE SKILLS**

AGE	SKILLS	EXAMPLE
5 - 7 Years*	Understands time concepts more abstractly.	Fall, winter, spring, summer.
	Understands quantity concepts.	Give me **half** of the sandwich.
	Understands sequences of time.	Tell me what you did **first.** Tell me what you did **last.**
	Understands "er" endings.	Which one is the **skater?**
	Use of "ly" adverbs.	She walked **softly.**
	Distinguishes between "a" and "the."	Point to **the** store you were in.
	Uses superlatives to describe.	He is a **better** player than me. Bill is the **best** player.
	Uses adjectives to describe people and objects.	He was a very tall and thin man.
	Can add and subtract numbers to 5.	What is 2 plus 2? What is 5 minus 4?
	Can retell a story with visual support.	Read or tell a story with a picture book. Then ask to have the story retold.
	Uses irregular plurals.	There is one mouse. There are five mice.

* There may be individual differences at each age level due to variation in the acquisition of language skills.

**Illinois Joint Training Initiative on Disability and Human Development, University of Illinois at Chicago. (1996). Abuse and Disability. Compiled from: Preschool Language Scale by the Psychological Corporation, Harcourt Brace Jovanovich Inc., 1991 & A Few Facts about Children's Learning Skills by Anne Graffam Walker, 1990.

AGE	SKILLS	EXAMPLE
8 - 12 Years*	Continued mastery of skills as previously listed.	See examples in previous charts.
	Continued growth of vocabulary.	This may depend on the individual child and his or her particular circumstances.
	Continued ability to use complex sentences and descriptions.	He was very tall and thin, wearing a red jacket with black trim. He was running very fast around the corner.
	Beginning to think more abstractly and to use more abstract concepts. The use of concrete language and examples is still important.	To say "describe the room" is appropriate, however, more concrete questions are better. "Tell me the color of the walls. Was there a chair in the room?"
	By age 12 basic language and communication skills have been established.	

11

PREVENTION CURRICULA FOR CHILDREN WITH DISABILITIES

The following child abuse prevention resources and curricula can be used or adapted to meet the needs of children with disabilities:

Briggs, F. (1995). *Developing personal safety skills in children with disabilities.* Baltimore, MD.: Brookes Publishing Co.

(Child safety curriculum that teaches children with disabilities to avoid hazardous situations and assert their rights in uncomfortable situations. Seven modules include self-esteem; assertiveness; hazards; body image; touching; talking about touching; and identifying feelings. Parent workshops.)

Champagne, M.P., & Walker-Hirsch, L.W. (1982). Circles: A self-organization system for teaching appropriate social/sexual behavior to mentally retarded/developmentally disabled persons. *Sexuality and Disability,* 5(3), 172-174.

(Children are taught to place people that they know in the appropriate circles and to recognize the kinds of social interactions that are acceptable in each.)

Crossmaker, M. (1986). *Empowerment: A systems approach to preventing assaults against people with mental retardation and/or developmental disabilities.* Columbus, OH: The National Assault Prevention Center.

(The Assault Prevention Program teaches a variety of personal safety skills and is suited for people living in group or institutional care.)

Edwards, J.P., & Elkins, T.E. (1988). *Just between us: A social sexual guide for parents and professionals with concerns for persons with developmental disabilities.* Portland, OR: Ednick Communications.

(Curriculum that teaches social/sexual content including socialization, normalization, dignity, and sexuality.)

Hingsburger, D. (1990b) i to I: *Self concept and people with developmental disabilities.* Mountville, PA: VIDA Publishing.

(Self-esteem program development.)

Medicine Hat Regional Association for the Mentally Handicapped. (1993). *Toward a better tomorrow.* Medicine Hat, Alberta, Canada: Author.

(Personal safety curriculum that focuses on recognition and avoidance of abuse and obtaining assistance. Contains information for families to help them recognize and respond effectively to abuse.)

Monat-Haller, R. (1992). *Understanding and expressing sexuality: Responsible choices for individuals with developmental disabilities.* Baltimore: Paul H. Brookes Publishing Co.

(Provides a review of sex education programs for people with disabilities.)

O'Day, B. (1983). *Preventing sexual abuse of persons with disabilities.* St. Paul: Minnesota Department of Corrections, Program for Victims of Sexual Assault.

(Sexual abuse prevention curricula for students with hearing or visual impairments, physical disabilities, and developmental disabilities.)

Rapport, S.R., Burkhardt, S.A., & Rotatori, A.F. (1997). *Child sexual abuse curriculum for the developmentally disabled.* Springfield, IL.: Charles C. Thomas Publisher Ltd.

(Ten lesson sexual abuse prevention program intended to teach children about their bodies and reinforce rules about safety and touching. Lesson outlines, sample stories, and recommendations for use with different ages.)

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The Lexington Center for Mental Health Services, Inc. Lexington Abuse and Disabilities Program. *Child abuse and disabilities: interviewing and investigatory strategies.* Presented by Michael M. Crocker at the Child Abuse and Disabilities Conference, 1994 Richmond, Virginia.

U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect. (1993). *Child sexual abuse: intervention and treatment issues.* The user manual series.

Virginia Code Sections 63.1-248.1-18 and 63.1-209.

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Virginia Department for the Visually Handicapped. (1998). *Summary provided by Paige E. Berry, Deafblind Services.*

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LOCAL DEPARTMENTS OF SOCIAL SERVICES

COUNTIES

Accomack County	757-787-1530
Albemarle County	804-972-4010
Alleghany-Covington County	540-965-1780
Amelia County	804-561-2681
Amherst County	804-946-9330
Appomattox County	804-352-7125
Arlington County	703-358-5100
Bath County	540-839-7271
Bedford County	540-586-7750
Bland County	540-688-4111
Botetourt County	540-473-8210
Brunswick County	804-848-2142
Buchanan County	540-935-8106
Buckingham County	804-969-4246
Campbell County	804-592-9585
Caroline County	804-633-5071
Carroll County	540-236-7181
Charles City County	804-829-9207
Charlotte County	804-542-5164
Chesterfield/Colonial Heights County	804-748-1100
Clarke County	540-955-3700
Craig County	540-864-5117
Culpeper County	540-825-1251
Cumberland County	804-492-4915
Dickenson County	540-926-1661
Dinwiddie County	804-469-4524
Essex County	804-443-3561
Fairfax County	703-324-7400
Fauquier County	540-347-2316
Floyd County	540-745-9316
Fluvanna County	804-842-8221
Franklin County	540-483-9247
Frederick County	540-665-5688
Giles County	540-626-7291
Gloucester County	804-693-2671
Goochland County	804-556-5332
Grayson County	540-773-2452
Greene County	804-985-5246
Greensville/Emporia County	804-634-6576
Halifax County	804-476-6594
Hanover County	804-752-4100
Henrico County	804-672-4002
Highland County	540-468-2199
Isle of Wight County	757-365-0880
James City County	757-259-3100
King & Queen County	804-785-7023

King George County 540-775-3544
King William County 804-769-4905
Lancaster County 804-462-5141
Lee County 540-346-1010
Loudoun County 703-777-0353
Louisa County.....540-967-1320
Lunenburg County 804-696-2134
Madison County.....540-948-5521
Mathews County.....804-725-7192
Mecklenburg County.....804-738-6138
Middlesex County 804-758-2348
Montgomery County 540-382-6990
Nelson County 804-263-8334
New Kent County.....804-966-9625
Northampton County 757-678-5153
Northumberland County 804-580-3477
Nottoway County 804-645-8494
Orange County.....540-672-1155
Page County.....540-743-6568
Patrick County 540-694-3328
Pittsylvania County 804-432-7281
Powhatan County 804-598-5630
Prince Edward County 804-392-3113
Prince George County 804-733-2650
Prince William County 703-792-7500
Pulaski County.....540-980-7995
Rappahannock County 540-675-3313
Richmond County 804-333-4088
Roanoke County.....540-387-6040
Rockbridge County 540-463-7143
Russell County 540-889-2679
Scott County 540-386-3631
Shenandoah County 540-459-3736
Smyth County 540-783-8148
Southampton County.....757-653-3080
Spotsylvania County.....540-582-7134
Stafford County.....540-659-8720
Surry County.....757-294-5240
Sussex County.....804-246-7020 x4
Tazewell County 540-988-2521
Warren County.....540-635-3430
Washington County 540-623-2661
Westmoreland County 804-493-9305
Wise County 540-328-8056
Wythe County 540-228-5493
York/Poquoson County 757-890-3930

continued

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LOCAL DEPARTMENTS OF SOCIAL SERVICES

continued

CITIES

Alexandria City	703-838-0800
Bristol City	540-645-7450
Charlottesville City	804-970-3400
Chesapeake City	757-382-2000
Clifton Forge City	540-863-2525
Danville City	804-799-6543
Franklin City	757-562-8520 x 257
Fredericksburg City	540-372-1032
Galax City	540-236-8111
Hampton City	757-727-1885
Harrisonburg City/Rockingham	703-574-5100
Hopewell City	804-541-2330
Lynchburg City	804-847-1531
Manassas City	703-361-8277
Manassas Park City	703-335-8880
Martinsville City/Henry	540-656-4300
Newport News City	757-926-6600
Norfolk City	757-664-6022
Norton City	540-679-2701
Petersburg City	804-861-4720
Portsmouth City	757-393-9500
Radford City	540-731-3063
Richmond City	804-780-8138
Roanoke City	540-853-2245
Staunton/Augusta City	540-245-5800
Suffolk City	757-539-0216
Virginia Beach City	757-437-3400
Waynesboro City	540-942-6646
Williamsburg City	757-220-6161
Winchester City	540-662-3807

RESOURCES

STATE

Child Abuse Hotline:
1-800-552-7096 *(Voice/TDD Accessible)*

Department of the Deaf and Hard of Hearing
1602 Rolling Hills Drive, Suite 203
Richmond, VA. 23229
1-800-552-7917 *(Voice/TDD Accessible)*

Department of Mental Health, Mental Retardation & Substance Abuse Services
Office of Human Rights
109 Governor Street
Richmond, VA. 23219
(804) 786-3988

Department of Mental Health, Mental Retardation & Substance Abuse Services
Children's Services, Office of Mental Retardation Services
P.O. Box 1797
Richmond, VA. 23214
(804) 371-2134

Department of Mental Health, Mental Retardation & Substance Abuse Services
Office of Early Intervention Services
P.O. Box 1797
Richmond, VA. 23214
(804) 786-3710

Department for the Rights of Virginians with Disabilities
202 North Ninth Street-9th Floor
Richmond, VA. 22219
1-800-552-3962 *(Voice/TDD Accessible)*

Department for the Visually Handicapped
397 Azalea Avenue
Richmond, Virginia 23227
(804) 371-3140 *(Voice/TDD Accessible)*

MCH-LEND Program
Virginia Commonwealth University
Virginia Institute for Developmental Disabilities
P.O. Box 980045
Richmond, VA. 23298-0405
(804) 828-0773

Parents and Children Coping Together (PACT)
8032 Mechanicsville Turnpike
Mechanicsville, VA. 23111
(804) 559-6833

Parent Education Advocacy and Training Centers
10340 Democracy Lane
Fairfax, VA. 22030
1-800-869-6782
http: //www.peatcinc@aol.com

Prevent Child Abuse, Virginia
4901 Fitzhugh Avenue, Suite 200
Richmond VA. 23230
(804) 359-6166

The Arc of Virginia
Autism Training and Family Support Program
6 North 6th Street, Suite 403-A
Richmond, VA. 23219
(804) 649-8481

continued

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RESOURCES
continued

Virginia Institute for Developmental Disabilities
Virginia Commonwealth University
700 East Franklin Street
Box 843020
Richmond, VA. 23235-0653
(804) 828-3876 *(Voice/TDD Accessible)*

Virginia Department of Social Services
Child Protective Services Unit
730 East Broad Street
Richmond, VA. 23219-1849
(804) 692-1259
Program Manager: Rita Katzman

NATIONAL

National Clearinghouse on Child Abuse and Neglect Information
330 C Street, SW
Washington, D.C. 20447
1-800-394-3366
www.calib.com/nccanch

National Information Center for Children and Youth with Disabilities
P.O. Box 1492
Washington, D.C. 20013
1-800-695-0285 *(Voice/TDD Accessible)*
http: //www.nichcy@aed.org

The National Information Center on Deafness (NICD)
Gallaudet University
800 Florida Avenue. N.E.
Washington D.C. 20002-3695
(202) 651-5051 *(Voice/TDD Accessible)*
http: //www.nicd@gallux.gallaudet.edu

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Assistance For
SPECIAL EDUCATORS, LAW ENFORCEMENT AND CHILD PROTECTIVE SERVICES
In Recognizing and Managing Abuse and Neglect of Children with Disabilities

Cut out or Copy this form and mail to:

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Child Protective Services Unit
730 East Broad Street
Richmond, Virginia 23219-1849
(804) 692-1259

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